**RESPONSIBLE PARTY DEMOGRAPHIC AND INSURANCE INFORMATION**

(Confidential information-Please fill out completely)

**RESPONSIBLE PARTY FULL NAME**_____**DATE**_____

**HOME PHONE**_____**CELL PHONE**_____**WORK PHONE**_____

**ADDRESS**_____**CITY**_____**STATE**____**ZIP CODE**_____

**EMPLOYER NAME & ADDRESS**_____

May we contact you at work? Yes No

**DATE OF BIRTH**_____REFERRED BY_____

**SOCIAL SECURITY#**_____**E-MAIL ADDRESS**_____

**EMERGENCY CONTACT NAME & PHONE#**_____

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**SPOUSE NAME**_____**DATE OF BIRTH**_____

**SPOUSE EMPLOYER NAME & PHONE#**_____

**SPOUSE SOCIAL SECURITY#**_____

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**PRIMARY DENTAL INSURANCE INFORMATION**

EMPLOYER NAME_____EMPLOYEE NAME_____
EMPLOYER ADDRESS_____EMPLOYER PHONE_____
INSURANCE CO. NAME_____ADDRESS_____
GROUP#_____MEMBER I.D.#_____

**2ND DENTAL INSURANCE INFORMATION**

EMPLOYER NAME_____EMPLOYEE NAME_____
EMPLOYER ADDRESS_____EMPLOYER PHONE_____
INSURANCE CO. NAME_____ADDRESS_____
GROUP#_____MEMBER I.D.#_____

**Consent for Treatment and Financial Agreement**

I authorize any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis and to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my (or the patient's) treatment. I also understand the use of anesthetic agents embodies a certain risk.
I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that a Finance Charge of .66% per month will be added to any balance over 60 days. This an Annual Percentage Rate of 8%. In the event of default I understand that I am financially responsible for collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____Date_____

Parent or Responsible Party_____Date_____