PATIENT ACQUAINTANCE FORM

PATIENT NAME: _____
Last **First** **MI**

Date of Birth: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Mobile Phone: _____
Social Security No: _____ Business Phone: _____
Employer: _____ E-mail: _____
Spouse Name: _____ Spouse Employer: _____

Who May We Thank For Your Referral? _____

INSURANCE INFORMATION

DENTAL INSURANCE:

Subscriber Name: _____
Insurance Co: _____
Insurance Phone: _____
Insurance Co. Address: _____
Subscriber SSN/ID#: _____
Subscriber DOB: _____

Secondary Insurance Company Information (if applicable)
List Policy Holder Name, Insurance Co. Address, Telephone, Policy No, Group No.:

CONSENT FOR TREATMENT

1. I hereby authorize the Doctor or designated Staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental deeds.

2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of an anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly I authorize my insurance benefits to be paid directly to the Doctor. I agree to be responsible of payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand that in the event that payments are not received by agreed upon dates, the balance may be added to my account.

SIGNED:_____**DATE:** _____