PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	DATE			•	1	DENTAL INSURANCE	2	
	LAST NAME		FIRST	M.I.		DENTAL I	INSURANCE	
	PREFERS TO BE CALLED BY					INSURANCE COMPANY		
IF THIS APPOINTMENT	ADDRESS					GROUP NO.		
IS FOR YOU	CITY STATE ZIP					EMPLOYER NAME		
START HERE	PHONE		FAX			INSURED'S NAME		
	CELL EMAIL					DATE OF BIRTH	RELATIONSHIP TO PATIENT	
	BIRTHDATE	AGE	MALE	FEMALE		INSURED'S I.D. NO.		
	MARRIED	SINGLE	DIVORCED	WIDOWED		INSURED'S SOCIAL SEC	URITY NO.	
	SOCIAL SECURITY NO.					SECONDARY CARRIER		
					INSURANCE COMPANY			
LAST NAME FIRS			FIRST	RST M.I.		GROUP NO.		
IF THIS	ADDRESS					EMPLOYER NAME		
APPOINTMENT IS FOR YOUR CHILD	PPOINTMENT CITY STATE			ATE ZIP		INSURED'S NAME		
START HERE	HOME PHONE N	Ю.				DATE OF BIRTH	RELATIONSHIP TO PATIENT	
	BIRTHDATE	AGE	MALE	FEMALE		INSURED'S I.D. NO.		
	SCHOOL			GRADE		INSURED'S SOCIAL SEC	URITY NO.	
	SOCIAL SECURI	TY NO.						
'								
	IF YOUR CHILD'S LAST N	IAME AND/OR ADDRES	S ARE NOT THE SAME AS	S YOURS, FILL IN THE TOP E	BOX ALSO			
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CONSENT FOR TREATMENT

1.	<i>,</i> ,	, study models, photographs, and other diagnostic aids deemed appropriate by 's dental needs.						
2.	Upon such diagnosis, I authorize 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 anesthetics, sedatives and other med certain risks. I understand that I can ask for a complete rec	cation as necessary. I fully understand that using anesthetic agents embodies ital of any possible complications.						
4.	time of service unless other arrangements have been made	red on my behalf or my dependents. I understand that payment is due at the e. In the event payments are not received by agreed upon dates, I understand y account. If required, I also understand a check of my credit history may be						
Pat	ient's Signature Date	Witness						
⊃at	ient's Signature	Patient's Signature						