RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

E-MAIL ADDRESS _____ SOCIAL SECURITY# _____

BIRTHDATE _____ DRIVER'S LICENSE# _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYER _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE

EMPLOYER _____ NO. YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC.# _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec# _____ Group# _____ Local# _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec# _____ Group# _____ Local# _____

***PLEASE READ AND SIGN THE FOLLOWING RESPONSIBILITY AND CONSENT STATEMENT:**

To the best of my knowledge, the above information is complete and correct. **I understand that I am responsible for any financial obligation incurred for the services provided.** I also authorize and request the performance of dental services for myself or my minor child and give my consent to any advisable and necessary dental procedures, medication, anesthetics or analgesics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. (You will be informed of planned services before services are rendered.)

DATE: _____ SIGNATURE: _____
(parent or guardian if patient is a minor)