PATIENT INFORMATION

Name_________________________________Nickname______________________________________Male/Female

Birthday________________ SS#___________________________________(Required to maintain balance on account)

Address: Street/City/Zip ____

Mailing Address____

Phone: Home______________Work_______________Cell_______________Email ___________________________

Employer/Address____Occupation ____________________________

Spouse_______________________________Work________________Cell__________________________________

Emergency contact (local) that does not live with you____

Phone________________________________Relationship ____

Whom may we thank for referr ing you to us ____

Primary Physician______________________________Office Phone _______________________________________

Specialty Physician_____________________________Office Phone _______________________________________

Previoius Dentist_______________________________Office Phone _______________________________________

Last Dental Cleaning_______________________ Last x-rays ___________Last treatment______________________

DENTAL INSURANCE

Who is responsible for this account___________________________________Birthday ________________________

Account holder address ____

Insurance Co.__________________________________ Group #_________________ID#______________________

Is patient covered by additional insurance? Circle Yes No

Subscriber's Name____________________________________ Birthday____________________________________

SS# ______________________Relationship to patient____

Insurance Co. _____________________________Group# ____________________ID#_________________________

CONSENT FOR TREATMENT

I herby authorize Ray Family Dental Care to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Ray Family Dental Care to perform all recommended treatment and to administer the appropriate medications or anesthetics mutually agreed upon. I understand that using anesthetic agents is optional and using them involve certain risks, such as, but not limited to, hematoma, parenthesis, allergic reactions, or increased heart rate. I will be given an opportunity to discuss any concerns or questions that I may have.

Signature ____ Date_______________________________________

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges in this office. All charges will be paid at the time of service unless written financial agreements were made in advance. Patients with insurance coverage must sign a copy of the office policy on filing insurance claims and assignment of benefits. I understand that this office does not render services on the assumption that the charges will be paid by an insurance company. I agree to pay all late fees, collection cost (40%), attorney's fees and any other costs that may be incurred to enforce collections of any outstanding amount. This office accepts cash, personal checks, Visa, MasterCard, and Discover. There is a return check fee of $30.00.

Signature ____ Date_______________________________________