Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City Prov Postal Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City Prov Postal Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City Prov Postal Code

Insured's Employer Name: _____

Address: _____
Street City Prov Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Address: _____
Street City Province Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Office Policy

When an appointment is made, that time is specifically reserved for you only and will not be given to any one else unless you call and cancel. When enough notice is not given **(min. 48 hours)** to cancel, a $50.00 charge will apply. (insurance plans do not cover this amount)

Office policy is that services are paid for each visit as they are performed. However in certain circumstances arrangements for payments may be made by consulting doctor.

Consent for Treatment

This is to certify that I, the undersigned consent to the performing of the dental procedures agreed to be necessary and I will be assume responsibility for fees associated with those procedures.

I authorize this office to contact my previous dentist, medical doctor{s}, insurance company, plan administrator at work and share information as needed, as well as to submit insurance claims electronically.

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Signature of Dentist: _____