Date_____ **PATIENT INFORMATION**

PATIENT NAME _____

HOME ADDRESS CITY, STATE, ZIP BIRTHDATE

MALE ☐ FEMALE ☐

HOME PHONE_____ MOBILE PHONE_____ WORK PHONE_____

RESPONSIBLE PARTY

NAME_____

HOME ADDRESS CITY, STATE, ZIP BIRTHDATE

RELATIONSHIP TO
PATIENT_____

RESPONSIBLE PERSON EMPLOYER MEMBER ID GROUP NUMBER

INSURANCE COMPANY COMPANY ADDRESS CONTACT NUMBER

WHOM MAY WE THANK FOR REFERRING YOU?

CONSENT

- **I will answer all health questions to the my best of my knowledge_____**
- **(initial)**
- **I hereby authorize the performance of dental services upon the above named patient. I authorize diagnostic procedures and treatment necessary in Dr. Ray's judgement,for proper dental care. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.**

SIGNATURE **DATE** **RELATIONSHIP TO PATIENT**

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the cost incurred. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services or any dental service performed without prior financial arrangements must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from my insurance company. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Signed_____**Date**_____

THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOINTMENT TIME.