AVONDALE DENTAL

***Whom may we thank for referring you to our office?*** _____

## PERSONAL INFORMATION

Mr./Mrs./Ms. _____ Nickname _____ Birth Date _____
Last First
Spouses First Name _____ If patient is a minor, parent's or guardian's name _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E mail address _____

Home Address _____ City _____ State _____ Zip_____

Billing Address _____ City _____ State _____ Zip _____

Drivers Lic. # _____ State _____ Social Security # _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency (not living with you) _____

Phone # _____ Relationship _____

## INSURANCE INFORMATION

PRIMARY Insurance Company _____ Group # _____

Name of Insured _____ SS or ID # _____ Birth Date _____

Relationship to Patient _____ Employer _____

SECONDARY Insurance Company _____ Group # _____

Name of Insured _____ SS or ID # _____ Birth Date _____

Relationship to Patient _____ Employer _____

## CONSENT

**1. The undersigned authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs, and to be used for instructional purposes as necessary.**

**2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me. I understand that dental treatments and anesthetic agents involve a certain risk. I authorize the doctor to employ any necessary treatment in the event of a medical emergency.**

**3. Payment is due when services are rendered unless other arrangements have been made.**

**4. To avoid any misunderstanding regarding your dental insurance, we wish our patients to know all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We are happy to submit your dental insurance claims to see that you receive the full benefits your coverage allows; however, we cannot guarantee estimated coverage. If for some reason your insurance company has not paid their portion within sixty days from the start of treatment, you are responsible for that portion at that time.**

**Patient/Guardian _____ Date_____**