DENTAL HISTORY

1. HAVE YOU EVER BEEN REQUIRED TO TAKE PREMEDICATION PRIOR TO A DENTAL VISIT? ________________
2. DATE OF LAST DENTAL TREATMENT:____________________________
3. DATE OF LAST FULL MOUTH XRAY:______________________________

INSURANCE INFORMATION

- DO YOU HAVE DENTAL INSURANCE?____YES NO

  1. NAME OF INSURANCE CARRIER:____
  2. ADDRESS FOR CLAIMS:____
  3. PHONE#:__________________________________GROUP#:___________________
  4. UNION NAME/LOCAL #:____
  5. NAME OF SUBSCRIBER:____
  6. SUBSCRIBER'S SOCIAL SECURITY#:___________________________BIRTHDATE:_________
  7. SUBSCRIBER'S EMPLOYER:____

- DO YOU HAVE DUAL COVERAGE/ SECONDARY INSURANCE PLAN?__________________________YES NO

  1. NAME OF INSURANCE CARRIER:____
  2. ADDRESS FOR CLAIMS:____
  3. PHONE#:_________________________________GROUP#:____________________
  4. UNION NAME/LOCAL#:____
  5. NAME OF SUBSCRIBER:____
  6. SUBSCRIBER'S SOCIAL SECURITY#:__________________________BIRTHDATE:__________
  7. SUBSCRIBER'S EMPLOYER:____

CONSENT FOR TREATMENT
The above health history is correct and complete to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient an/or Guardian to be necessary or advisable, including the use of local anesthetic and other medication as indicated. I agree that regardless of insurance coverage, *I am responsible for payment of services rendered and that a finance charge of 1.5% will be applied to accounts past sixty days. If special financial arrangements are requested, a credit report may be obtained.* I agree that in the event of a dispute, arbitration is mandatory as a means of resolution.

____ ____________________________

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN **DATE**

INSURANCE AUTHORIZATION/SIGNATURE ON FILE
(PLEASE CHECK WHERE APPLICABLE)

◊ I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS

◊ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS

◊ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR

◊ I AUTHORIZE MY DOCOTR TO ACT AS MY AGENT IN OBTAINING PAYMENT FROM INSURANCE CARRIERS

◊ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

NAME:________________________________**SIGNATURE:**________________________**DATE:**________