DENTAL INSURANCE

NAME OF INSURANCE COMPANY_____

INSURANCE CO. ADDRESS _____

GROUP # _____

PHONE # _____

ID # _____

PURPOSE OF VISIT

LAST DENTAL VISIT _____ REFERRED BY _____

ARE YOU A FORMER PATIENT? _____ IS THERE ANYTHING ABOUT YOUR SMILE

YOU WOULD CHANGE? _____

NAME OF YOUR PHYSICIAN (MEDICAL DOCTOR) _____

EMERGENCY CONTACT (NAME)_____ _____
(OTHER THAN SPOUSE OR PARENT)
RELATION _____ PHONE # _____

TREATMENT AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR MYSELF AND FOR:

_____ AGE _____

_____ AGE _____

I ALSO GIVE MY CONSENT TO ANY ADVISABLE AND NECESSARY DENTAL PROCEDURES, MEDICATIONS, ANESTHETICS ADMINSTERED BY THE ATTENDING DENTIST OR BY HIS/HER SUPERVISED STAFF FOR DIGNOSTIC PURPOSES OR DENTAL TREATMENT. I GIVE DR. DWYER PERMISSION TO TAKE PHOTOS THAT MAY BE USED FOR LECTURES AND/OR EDUCATIOANL PURPOSES.

I UNDERSTAND AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED FOR MYSELF AND/OR THE ABOVE NAMED, REGARDLESS OF INSURANCE COVERAGE.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP TO OTHERS NAMED

DATE_____

I WILL PAY FOR DENTAL SERVICES BY: (PLEASE CIRCLE ONE)

CASH CREDITCARD CHECK CARECREDIT