PATIENT INFORMATION

Date: _____

Patient Name: _____
(Last) (First) (M.)

Social Security No. _____

Address: _____
STREET CITY ZIP

Birth Date: _____ Sex M/F Martial Status _____

Home Phone _____ Cellular _____ Work _____

Place of Employment _____

Spouse's Name _____

IF PATIENT IS UNDER 18

Legal Guardian Name: _____ Relationship to Patient: _____

Address: _____ City _____ St_____ Zip_____

DENTAL INSURANCE INFORMATION

Please have your insurance card available for us to make copy. We MUST have this (*) information in order to file with your insurance

Insured Name* _____ SS# _____

Employer's Name _____ Employers Address _____

Insured Date of Birth _____ Relation to Patient _____

Contract or Member ID# _____ Group #_____

EMERGENCY CONTACT

List an emergency contact other than someone in your home:

Name _____ Phone No: _____ Relationship _____

AUTHORIZATION AND CONSENT

I undersigned hereby grant permission to Dr. Keith Brown and staff to administer treatment and/or medication necessary for proper dental care. I authorize this office to release any information necessary to my insurance carrier. I understand that I am responsible for the balance of my account at the time the treatment is rendered. In the event I fail to pay my account when due, I agree to pay in addition to any balance due all costs incurred by this office for collection including a reasonable attorney's fee.

_____ _____
Signature of Responsible Party Date

- IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE GIVE 24 HOUR NOTICE, NOT SHOWING UP FOR YOUR APPOINTMENT WILL RESULT IN A $25.00 CHARGE

- PAYMENT IS DUE AT TIME OF SERVICE