

Separated Widowed
Divorced Single
Child Married

PATIENT INFORMATION

NAME _____ BIRTH DATE _____ SEX _____
SOC. SEC. NO. _____ HOME PHONE () _____
ADDRESS _____ CITY _____ ZIP _____
SCHOOL (If full time student) _____ CITY _____
PREVIOUS DENTIST _____ CITY _____ LAST VISIT _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME (Head of Household) _____ RELATIONSHIP TO PATIENT _____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE () _____
NAME (Spouse of Head of Household) _____
OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____
EMPLOYER _____ ADDRESS _____ PHONE () _____
BANK _____ BRANCH _____ CHECKING _____ SAVINGS _____
NEAREST RELATIVE IN THE AREA _____ ADDRESS _____ PHONE () _____

ACKNOWLEDGEMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, or his qualified designate. I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, **at the time of service**, unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a service charge of 1 1/2 % per month (18% annual percentage rate), and I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account. I understand that where appropriate, a credit check may be made through a credit bureau.

Signed: Patient, Parent or Agent _____ Date: _____
Relationship to Patient _____

FOR PATIENTS WITH DENTAL INSURANCE

INSURED PERSON'S NAME _____ BIRTH DATE _____
INSURANCE COMPANY _____ GROUP NO. _____ UNION/LOCAL NO. _____
INSURED PERSON'S NAME (if dual) _____ BIRTH DATE _____
INSURANCE COMPANY _____ GROUP NO. _____ UNION/LOCAL NO. _____
INSURANCE COMPANY ADDRESS _____

INSURANCE RELEASE

AUTHORIZATION TO PAY AND TO RELEASE INFORMATION. I hereby authorize insurance benefit payments directly to Dr. Licking for their services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original. I also authorize Dr. Licking to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

Signed: Patient, Parent, or Agent _____ Date _____
Relationship to Patient _____