SOUTH SOUND DENTAL CARE

Welcome to our office. To assist us in serving you please complete the following form. Information is completely confidential.

Account ____________________

A. PERSONAL INFORMATION (If patient is a minor, form must be completed by parent)

Today's Date ______________ ***Is another family member a patient at this office?*** *Y N* Their Name________________

Patient Name ____ **Male**____ **Female**____

Home Address ____ **Birthdate**____________________

Billing Address (if different) ____

City / State ______________________________ **Zip Code**____________ **SSN** ____________________

Home Phone (_____)________________________ **Cell Phone Number (_____)** ____________________

*Employer ____ Occupation ____________________

EMAIL ____

Please check how would like to be reminded of upcoming appointments: ______email ____text _____phone

Spouse's Name ____ Occupation ____________________

Spouse Employer ____ Work Phone ____________________

If patient is a minor: **Name of parent** ______________________________ ***(Please complete above *employer info.)***

Person financially responsible for account____

***EMERGENCY CONTACT: Name of person not living with you** ______________________________

Relationship ________________________ **Phone (___)**________________________

B. DENTAL INSURANCE INFORMATION

Subscriber's Name __________________________ Primary Insurance Co. ______________________________

Group/Policy # __________________________ Birthdate ____________________ SSN ____________________

Are you covered by a 2nd plan? ________ Insurance Co. ________________________ Group/Policy #________________

Subscriber's Name __________________________ Birthdate ________________ SSN ____________________

CONSENT: I authorize the staff of South Sound Dental Care (SSDC) to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by SSDC to make a thorough diagnosis of the patient's dental needs. I also authorize SSDC to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that SSDC choose and employ such assistance as they deem fit. This includes, but is not limited to, all fillings, crowns, dental cleanings, root canals, extractions, and dentures. I understand there are inherent risks for each treatment and it is my responsibility to discuss my concerns with the doctor. I also understand the use of anesthetic agents embodies a certain risk.

APPOINTMENTS: I understand **there will be a $50.00 charge per scheduled hour for patients who cancel or miss appointments without one-business days' notice.**

INSURANCE: I hereby authorize payment of Group Insurance Benefits, otherwise payable to me, directly to South Sound Dental Care to be applied against my account. I also authorize South Sound Dental Care to provide any insurance company(s) information concerning health care advice, treatment or pre-authorization for treatment, and supplies provided for the purpose of evaluating and administrating claims for benefits.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the above information is true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist or his staff of any changes at any subsequent appointment.

Print Name: ______________________________

Signature:______________________________ **Date:**______________________________