Welcome

Patient Information

Today's Date_________________________________

Name____Date of Birth ____

Social Security # ____ Driver's License # ____ Sex____________

Address ____City, St, Zip ____

Home Phone _____________________________________Work Phone __________________________________ Cell Phone____

E-mail____ ___________________________________

Employer____Employer Address____

Check appropriate box: Married [ ] Single [ ] Divorced [ ] Widowed [ ] other [ ] Minor [ ]

Preferred Method of Communication: Phone Call **[ ]** Text **[ ]** (cell phone provider_____________________________) Email **[ ]**

Referred to our office by: ____

Responsible Party Information

Name of Responsible Party ____Social Security # __________________________________

Relationship to patient____

Address (if different than patient) ____City, St, Zip ____________________________________

Occupation ____Employer ____

Employer's Address ____ Employer's phone ______________________________

Dental Insurance Information

Insurance Company Name ____ Employer ____

Insured Name ____ _______________________

Insured Date of Birth ____ Relationship to Patient ____

Subscriber Id #____Group # ____

Insurance Company Address ____

Insurance Company Phone # ____

Secondary Insurance Information

Insurance Company Name ____ Employer ____

Insured Name ____

Insured Date of Birth ____Relationship to Patient ____

Subscriber Id # ____Group# ____

Insurance Company Address ____

Insurance Company Phone # ____

Emergency Contact

Name of Relative **NOT LIVING** with you____

Relationship to you____ Phone# ____

Address ____City, St, Zip ____

Examination and Diagnosis

The undersigned hereby authorizes Dr. Asseff to perform an intra-oral examination; to take x-rays, make diagnostic models, photographs, or any other diagnostic aids deemed appropriate by Dr. Asseff in establishing a thorough diagnosis of my dental needs.

I give my authorization to Dr. Asseff to perform treatment, prescribe medication, and make referrals to specialists, as she deems necessary.

I understand that the use of medications, anesthetic agents and some dental materials embodies a certain risk.

I understand that I may decline part of all of the treatment Dr. Asseff describes, but that I, not Dr. Asseff, will be responsible for any injury to my dental health caused by my declining treatment.

The Treatment

I understand that Dr. Asseff will create a treatment plan based on her diagnostic findings and that the treatment plan will serve as a guide to completing my care.

I also understand the treatment plan is only a guide and that, as procedures are performed, my treatment plan may need to be altered to accommodate changes in my dental condition.

I understand that, although I am expected to pay for my treatment, the treatment plan is in no way a business contract that binds either me to payment of Dr. Asseff to completion of this initial content.

I authorize Dr. Asseff to release any information including:

Diagnosis and the records of any treatments or examinations rendered to my child or me during the period of such dental care, to third party payers and/or other health care practitioners.

I authorize and request my insurance company to pay directly to Dr. Asseff insurance benefits otherwise payable to me.

I understand that me dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

Patient (Print Name) ____

Patient or Responsible Party Signature ____

Date ____

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