SCHMITT & MIDKIFF
GENERAL DENTISTRY

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____

Date_____Witness_____

Parent/Responsible Party's Signature

_____

Relationship to Patient_____

SM9300 (10/10)

PATIENT'S REGISTRATION

Please complete the following confidential information

Patient Registration

PATIENT INFORMATION

If this appointment is for you, start here:

DATE

LAST NAME FIRST M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY STATE ZIP

HOME PHONE NO. CELL NO.

E-MAIL ADDRESS

BIRTHDATE AGE MALE FEMALE

MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY NO.

If this appointment is for your child, start here:

DATE

LAST NAME FIRST M.I.

ADDRESS

CITY STATE ZIP

HOME PHONE NO.

BIRTHDATE AGE MALE FEMALE

SCHOOL GRADE

SOCIAL SECURITY NO.

(If your child's last name, and/or address are not the same as yours, fill in the top box also.)

FAMILY INFORMATION

Is another member of your family or relative a patient at our office?

NAME RELATIONSHIP

You were referred to us by

Your former address

CITY STATE ZIP

Person to contact for emergency

PHONE NUMBER

ADDRESS

CITY STATE ZIP

Closest relative not living with you

PHONE NUMBER

ADDRESS

CITY STATE ZIP

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT SOCIAL SECURITY NO.

ADDRESS

CITY STATE ZIP

PHONE NUMBER

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS

CITY

PHONE NO. FAX NO.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS CITY

PHONE NO. FAX NO.

Please turn over and sign