Patient information

Name: _____Sex:_____

Address: _____Marital Status_____

City: _____State:_____ Zip Code_____

Birth Date: _____SSN:_____--_____--_____

Employer: _____Occupation: _____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email: _____@

_____

Emergency contact name: _____Phone Number: _____

Physician Name: _____Phone Number: _____

Are any other members of your family patients of this office? YES / NO Name_____

Who may we thank for referring you to our office? _____

Responsible Party Information *If same as above, leave blank*

Name: _____Sex:_____

Address: _____Relationship to patient_____

City: _____State:_____ Zip Code_____

Birth Date: _____SSN:_____--_____--_____

Employer: _____Occupation: _____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Relationship to patient:

_____

Dental Insurance Information

Dental Insurance Name: _____

Group #: _____

Phone Number: _____

Subscriber information

Name: _____

ID #: _____ Birth Date: _____

Employer: _____

Relationship to patient: _____

Consent for Services

I hereby authorize Dr. Nekia Staley-Neither and staff to take and all necessary x-rays, study models, and photographs deemed necessary to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Nekia Staley-Neither and/or staff to perform any recommended treatment mutually agreed upon. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that the use of medications and anesthetic agents embodies certain risks. I understand that I can request a full recital of any such risks or potential complications.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

_____Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party