

POWDER RIVER DENTAL

PATIENT INFORMATION

Please complete the following confidential information.

PATIENT INFORMATION

DATE _____

NAME _____

SPOUSE _____

STREET ADDRESS _____

MAILING ADDRESS _____

CITY _____ ST _____ ZIP _____

HOME PHONE NO. _____

WORK PHONE NO. _____ EXT. _____

CELL PHONE NO. _____

E-MAIL: _____

BIRTHDAY _____ AGE _____ M / F

___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED

SOCIAL SECURITY NO. _____

SCHOOL/COLLEGE _____

GRADE/CREDITS _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE

CIRCLE ONE: Self Parent Guardian Foster Other

NAME _____

OCCUPATION _____

EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ ST _____ ZIP _____

BUSINESS PHONE NO. _____

NAME (spouse) _____

OCCUPATION _____

EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ ST _____ ZIP _____

BUSINESS PHONE NO. _____

GETTING TO KNOW YOU

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME _____

PHONE NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DENTAL INSURANCE

PRIMARY INSURANCE COMPANY _____

GROUP NUMBER _____

EMPLOYER _____

EMPLOYEE _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYEE SOCIAL SECURITY NO. _____

OUR OFFICE WILL FILE PRIMARY INSURANCE ONLY

TURN OVER AND SIGN

CONSENT FOR TREATMENT

1. I hereby authorized doctors and designated staff to take x-rays, study models, photographs and any 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 doctors 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 I can ask for a complete recital of any possible complications.
4. This consent shall remain in effect and relied upon by Powder River Dental Associates, Inc., for purposes of providing treatment to the named individual. This reliance shall continue until the consent is revoked.
5. This Consent For Treatment form is signed on behalf of my minor child. I agree to indemnify and hold harmless, to the extent permitted by law, any claims made on behalf of the child for treatment made while the child is still a minor. I agree to be bound by the terms of the treatment and acknowledge that I am responsible for all care and treatment provided to my minor child.
6. Lastly, I agree to be responsible for payment for 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 1 1/2% late charge (18% APR) may be added to my account.
7. Parents must accompany all minor children.

Patient _____ Date _____ Witness _____

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Parent or Responsible Party _____

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