PATIENT INFORMATION

Patient name _____ DOB _____ Sex _____ Date _____
Home phone _____ Cell phone _____ Work phone _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Driver License # _____ State _____
Patient's Employer _____ Occupation _____
Spouse's name _____
Who should we notify in case of emergency? _____ Phone _____

Person responsible for account _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Cell phone _____ Work phone _____
Employer _____

INSURANCE ASSIGNMENT AND RELEASE

Dental Insurance Company _____ Insured _____
ID # _____ Group # _____ Insured birthdate _____

I assign and authorize that payment of insurance benefits be directed to Central Coast Dental for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the release of medical information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim.
Patient (parent/guardian) signature _____ Date _____

FINANCIAL AGREEMENT

I understand that payment is due at the time of treatment. I agree that parents (guardians) are responsible for fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services rendered. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. If my account becomes past due, it may be referred to an outside collection agency without further notice.
Patient (parent/guardian) signature _____ Date _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Central Coast Dental to perform dental services for myself (or minor/child), including but not limited to x-rays, exam, cleaning, fillings, extractions, root canals, crowns, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I further consent to the administration of anesthetics, antibiotics, analgesic, or any other drug that may be deemed necessary. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of these procedures.
Patient (patient/guardian) signature _____ Date _____