PATIENT INFORMATION - MINOR

THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

PATIENT'S NAME _____BIRTHDATE_____

RESIDENCE ADDRESS_____

SCHOOL_____GRADE_____PHONE NO. ( )_____

FATHER'S NAME_____BIRTHDATE_____

DRIVER'S LICENSE NO._____SOCIAL SECURITY NO._____/____/_____RES. PHONE ( )_____

EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____BUS. PHONE ( )_____

. . . . . .

MOTHER'S NAME_____BIRTHDATE_____SOC.SEC.NO._____

EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____BUS. PHONE ( )_____

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NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____RELATIONSHIP_____

COMPLETE ADDRESS_____RES. PHONE ( )_____

NAME OF PHYSICIAN_____PHONE ( )_____

PURPOSE OF APPOINTMENT_____

WHOM MAY WE THANK FOR REFERRING YOU ?_____

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PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP_____

ADDRESS_____PHONE ( )_____

PREFERENCE OF PAYMENT; CASH_____CHECK_____CREDIT CARD_____

BANK_____ACCOUNT NO._____

INSURANCE COMPANY_____GROUP NO._____

INSURED PERSON'S NAME_____EMPLOYEE NO._____

SECONDARY INSURANCE CO._____GROUP

NO._____

INSURED PERSON'S NAME_____EMPLOYEE NO._____

. . . . . .

CONSENT FOR TREATMENT: I HEREBY GRANT AUTHORITY TO THE DENTIST (S) IN CHARGE OF THE CARE OF THE PATIENT WHOSE NAME APPEARS ON THIS FORM, TO ADMINISTER SUCH ANESTHETICS, ANALGESICS, SEDATIVES, OR NITROUS OXIDE SEDATION; AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THIS PATIENT. I HAVE BEEN INFORMED OF ALL POSSIBLE COMPLICATIONS OF THE PROCEDURES, ANESTHETICS AND / OR DRUGS.

SIGNED_____DATE_____

INSURANCE AUTHORIZATION
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

SIGNED_____DATE_____

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