



Home Address: _____

Home Address: _____

Insurance Company Name: _____ Insurance Company Phone Number: (____) _____

Emergency Contact Phone Number: ()

[illegible]

When was your Last Dental Visit: _____ **Previous Dental Office:** _____

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor/or his staff. I agree to pay for all services rendered by this office.

Signature: _____ **Date:** _____