



Patient Information

Patient Name: _____
Last First M.I.

SS#: _____

Age: _____ Sex: Male Female

Birthdate: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Address: _____ City: _____ State: _____

Email: _____

Occupation: _____ Employer/School: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact Name/Phone #: _____

Whom may we thank for referring you? _____

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of 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 payment is not received I understand that a 1.5%late charge (18%APR) may be added to my account.

_____ Date: _____

Signature of Patient, Parent, Guardian, Personal Representative



Account Information

Person responsible for this account: _____

Relationship to patient: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Address: _____ City: _____ State: _____

Email: _____

Insurance Co.: _____

Group#: _____

Subscriber's Name: _____

DOB: _____ SS/ID#: _____

Secondary Insurance Co: _____

Group#: _____

Subscriber's Name: _____

DOB: _____ SS/ID#: _____

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Thompson all insurance benefits, if any, otherwise payable for 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.

Dr. Thompson may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian, Personal Representative Date: _____