THOMPSON
FAMILY DENTAL

4526 Rinetti Lane, La Cañada, CA 91011
Tel: (818) 790-5220 | Fax: (818) 790-5227

Patient Information

Patient Name: _____
Last First M.I.

SS#: _____

Age: _____ Sex: ❑ Male ❑ Female

Birthdate: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

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

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Account Information

Person responsible for this account: _____

Relationship to patient: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

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.

_____ Date: _____

Signature of Patient, Parent, Guardian, Personal Representative