Meadow Vista Dental Care

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Patient's Name____ Date of Birth________________________

Mailing Address_____________________________ City_____________________________ State_____ Zip_________

Street Address_______________________________ City____________________________ State_____ Zip_________

Home Phone___________________ Cell Phone_____________________ Email________________________________

Your Employer____ Business Phone________________________

Occupation_________________ Social Security #____________________Driver's License# ______________________

Spouse's Name____ Business Phone___________________

Nearest relative not living with you____ Phone___________________

Whom may we contact in case of emergency?__________________________________ Phone___________________

Names and ages of children under the age of 18 ____

Whom may we thank for referring you to us? ____

PATIENT CONSENT FOR DENTAL TREATMENT

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives or x-rays as may be deemed necessary by the Doctor. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental are to third party payers and/or health practitioners. I authorize and request my Insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services an I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

________________________________ **Relationship** ○ Patient ○ Parent ○ Guardian/Conservator

Signature

INSURANCE INFORMATION

Employee/Subscriber's Name_______________________________________ Date of Birth________________________

Employee/Subscriber's Social Security Number(If different from that shown above)____________________________

Patient's relationship to Employee/Subscriber ○ Child ○ Spouse ○ Self ○ Other

Name of Dental Insurance Company____ Group #___________

Employer_______________________________City_____________________________State________Zip___________

If patient is a Student, School Attended____ ○ Full Time ○ Part Time

IF PATIENT IS COVERED BY MORE THAT ONE INSURANCE COMPANY, PLEASE PROVIDE ADDITIONAL INFORMATION BELOW

Name of Dental Insurance Company____ Group #___________

Employee/Subscribers Name_______________________________ Social Security # __________________________

Employer_______________________________City_____________________________State________Zip___________

Acknowledgement: I have received the Dental Material Fact Sheet _________________________Date__________