



Patient Information

Name _____ Nickname _____

Age _____ Date of Birth _____ Marital Status _____ Male _____ Female _____

Social Security # _____

Address _____ City _____ St _____ Zip _____

Home # _____ Cell # _____ Work# _____

Employed By _____

Email Address _____

Whom may we thank for referring you? _____

How would you like your appointments confirmed? (Please circle one) HOME CELL WORK

Is it okay to leave a message? Y or N

Spouse's Name _____ Date of Birth _____ SSN _____

Cell Phone _____ Spouse Employed By _____

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Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

## Financial Information

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. In some cases, a credit report may be obtained. A service charge of 1% per month (12% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days.

I have read the above conditions of treatment and agree to their contents.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

### CONSENT FOR TREATMENT:

I hereby grant authority to Borealis Dental Studio, Dr. Sean Goolsby and staff to administer treatment; or to administer such anesthetics, analgesics and sedatives; 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 possible complications of the procedures, anesthetics, and/or drugs.

Signed \_\_\_\_\_

Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_