

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Best time to call: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Previous Dentist _____ Address _____

Date of last dental visit _____ What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most/least about your last dentist? _____

Consent for Services

I authorize and give consent to perform dental services agreed between doctor and patient or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

I authorize direct payment of dental benefits to which I am entitled to Robert Sattler, D.M.D. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should my account fall delinquent I will also be responsible for any accessed collection fees.

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

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____