Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Age _____ Sex _____

Phone - Home ( ) _____ Work ( ) _____

Cell ( ) _____ Fax ( ) _____

E-mail ( ) _____ Occupation _____

Martial Status _____ Spouses Name _____

Employer's Name & Address _____

_____

Emergency Contact: Name, Address & Phone # of a relative or friend not living with you:

_____

_____

Whom may we thank for referring you? _____

Dental Insurance Information

Dental Insurance Company _____ Telephone # _____

Address _____ City/State _____ Zip _____

Insured Employee _____ Date of Birth _____ Relationship to patient _____

Employer (Name & Address) _____

Employ Social Security # _____ Group Policy # _____

I authorize the release of any information to my insurance company necessary to file a claim.

Signature X _____

CONSENT FOR TREATMENT

I authorize Dr. Alman /Katz or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a through diagnosis of my dental needs and to preform any and all forms of treatment to include medication and therapy. I understand the use of anesthetics embodies a certain risk. Upon diagnosis, I authorize the doctor to preform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
I hereby certify that I have read and fully understand consent for treatment.

Signature of Patient or Guardian X _____ **Date** _____