



Willow Bend Dental

Patient Information

Contact Information

Name: _____
First Middle Last Preferred Name

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Age: _____ Gender: Female Male Family Status: Single Married Widowed

Social Security #: _____ Date of Birth: _____ DL # _____

Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Numbers: _____

The following is for: the patient the person responsible for payment

Employer: _____ Occupation: _____ Phone #: _____

Responsible Party Information

Name: _____
First Middle Last Relationship to Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ DL # _____

If Appointment For Your Child

Name: _____
First Middle Last Relationship to Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Social Security #: _____ Date of Birth: _____

Age: _____ Gender: Female Male Grade Level: _____

Getting To Know You

Whom may we thank for referring you to our practice? _____

Friend Relative Dental Office Internet School Work Other: _____

Name: _____
First Middle Last Relationship to Patient

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Insurance Information

Primary Carrier

Insurance Company: _____ Insurance Phone: _____

Group Number: _____

Employer's Name: _____

Insured's Name: _____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Insured's I.D. #: _____ Insured's Social Security #: _____

Secondary Carrier

Insurance Company: _____ Insurance Phone: _____

Group Number: _____

Employer's Name: _____

Insured's Name: _____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Insured's I.D. #: _____ Insured's Social Security #: _____

Dental Treatment Consent Form

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. 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.
3. I agree to the use of anesthetics, sedatives and other medication 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.
4. 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 payments are not received by agreed upon dates, I understand that a 1½ % late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.
5. **FOR YOUR INFORMATION – PLEASE READ OFFICE POLICY**

WE WOULD LIKE YOU TO BE INFORMED ABOUT OUR POLICIES. Please take a few moments to read and acknowledge this:

FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges, or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due payable when the initial impression is made.

AS A COURTESY TO YOU, Willow Bend Dental will, if necessary, accept 50% of this amount at the time of the impression. The balance must be at the time of permanent seating, or no more than 30 DAYS from date of impression, WHICHEVER COMES FIRST, unless prior arrangements have been made with our office manager. We accept insurance for payment; however, you must pay your portion at the time services are rendered.

PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOU COMFORT, AND PROPER FIT. If you fail to have your prosthetics seated within 60 days from the date of impression, and a second impression must be made, you will be charged an additional amount of one-half of our current charge for such procedure.

WE OFFER YOU QUALITY DENTAL CARE, ECONOMICALLY PRICED, and we want you to feel comfortable with all of our treatments and policies. Please feel most welcome to contact our office manager for any questions you may have.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Guardian Signature: _____ Relationship to Patient: _____