MINOR'S PATIENT INFORMATION

Name:_____Nickname_____Male/Female

Birthday _____ SS#_____ School/Phone _____

Address: Street-City-Zip _____

Mailing Address _____

Patient lives with _____ Relationship_____

Phones: Home_____ Work _____ Cell_____ School _____

Father _____ SS#_____ (Required to maintain balance on account)

Address: Street-City-Zip _____

Phones: Home_____ Work _____ Cell_____ E mail _____

Employer _____ Occupation_____

Mother _____ SS#_____ (Required to maintain balance on account)

Address: Street-City-Zip _____

Phones: Home_____ Work # _____ Cell_____ E mail _____

Employer _____ Occupation_____

Emergency contact (local) other than parents listed above _____

Phone _____ Relationship_____

Primary Physician _____ Office Phone _____

Specialty Physician_____ Office Phone _____

Former Dentist _____ Office Phone_____

Last Dental Cleaning _____ Last x-rays_____ Last Treatment _____

Whom may we thank for referring you to us? _____

CONSENT FOR TREATMENT

I hereby authorize Dr. Trichak to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Trichak to perform all recommended treatment and to administer the appropriate medication or anesthetics mutually agreed upon by me. I understand that using anesthetic agents is optional and using them involves certain risks, such as, but not limited to, hematoma, paresthesia, allergic reaction, or increased heart rate. I will be given an opportunity to discuss any concerns or questions that I may have. I certify that I have the authority to provide this consent.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges incurred in this office. All charges will be paid at the time of service unless written financial arrangements were made in advance. Patients with insurance coverage must sign a copy of the office policy on filing insurance claims and assignment of benefits. I understand that this office does not render services on the assumption that the charges will be paid by an insurance company. I agree to pay all late fees, collection costs (40%), attorney's fees and any other costs that may be incurred to enforce collections of any outstanding amount. This office accepts cash, personal checks, Visa, MasterCard, American Express and Discover. There is a return check fee of $30.00 for any reason.

Signature_____ Date _____