DAVID A. WARNER, D.D.S.
PERIODONTICS

Patient Information

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Patient's name _____ Spouse's name _____

If patient is a minor, give parent's or guardian's name _____

Residence address _____ City _____ Zip _____

Res. Phone _____ Birthdate _____

Employed by _____ Occupation _____

Business address _____ Bus. Phone _____

Spouse employed by _____ Occupation _____

Business address _____ Bus. phone _____

Name of nearest relative not living with you _____ Relationship _____

Address _____ City _____ Phone _____

Name of physician _____ Address _____ Phone _____

Referred by _____

Financial Information

Person responsible for this account _____ Relationship _____

Address _____ Phone _____

Preference of Payment

Cash on day of treatment _____

Dental Insurance Company _____ Spouse's Dental Insurance Co. _____

Social Security No. _____ Spouse's Soc. Sec. No. _____

Insurance Group No. _____ Spouse's Ins. Group No. _____

Terms and Conditions

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 patients insurance forms to assist in making collections from insurance companies and will credit any such collections to the patients account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient examination.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist (s) in charge of the care of the patient whose name appears on this Health History form to administer any treatment, or to administrate such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; 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 all possible complications of the procedures, anesthetics and/or drugs.

"ALL SERVICES ARE RENDERED AND ACCEPTED UNDER THE TERMS AND CONDITIONS PRINTED ABOVE"

Signed _____ Date _____

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

Relationship _____