ROUND ROCK PERIODONTICS

PATIENT INFORMATION

NAME_____ NICKNAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____ APT/SUITE#_____
HOME# (_____)_____-_____ CELL# (_____) _____-_____
WORK# (_____) _____-_____ DRIVERS LICENSE#_____
DATE OF BIRTH_____/_____/_____ EMAIL_____
SOCIAL SECURITY#_____-_____-_____ EMPLOYER_____

PARENT/or RESPONSIBLE PARTY INFORMATION

NAME_____ NICKNAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____ APT/SUITE#_____
HOME# (_____)_____-_____ CELL# (_____) _____-_____
WORK# (_____) _____-_____
DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY#_____-_____-_____

INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE#(_____)_____-_____
INSURANCE ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
INSURED NAME_____ EMPLOYER_____
DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY#_____-_____-_____

EMERGENCY CONTACT

NAME_____ RELATION_____ HOME# (_____)_____-_____
ADDRESS_____

CONSENT FOR SERVICE

Financial arrangements must be made in advance. All emergency dental services performed without previous financial arrangements, must be paid for at time the services are performed.
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 patient's insurance forms or assist in making collections to the patient's account. However, this office can not render services based on the assumption that our charges will be paid by an insurance company.
I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of examination. I grant my permission to be telephoned at home or work to discuss matters related to this.

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

Signature of patient or guardian:_____ **Date:**_____/_____/_____ **Relation:**_____