Family Dentistry
James R. Churchman, DDS

INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MI LAST

RELATIONSHIP
TO PATIENT _____ BIRTHDATE _____ SS # _____

EMPLOYER _____ WORK # _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

INSURANCE CO. _____

PHONE # _____ GROUP # _____ POLICY/I.D. #_____

INS. CO. ADDRESS _____ CITY _____ ST _____ ZIP_____

MAX. ANNUAL BENEFIT? _____ HOW MUCH IS YOUR DEDUCTIBLE? _____ AMOUNT USED? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO

NAME OF INSURED _____
FIRST MI LAST

RELATIONSHIP
TO PATIENT _____ BIRTHDATE _____ SS # _____

EMPLOYER _____ WORK # _____

EMPLOYER ADDRESS _____ CITY _____ ST _____ ZIP _____

INSURANCE CO. _____

PHONE # _____ GROUP # _____ POLICY/I.D. #_____

INS. CO. ADDRESS _____ CITY _____ ST _____ ZIP_____

MAX. ANNUAL BENEFIT? _____ HOW MUCH IS YOUR DEDUCTIBLE? _____ AMOUNT USED? _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designed staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient) _____'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the staff such as an assistant as required to provide proper care.
3. I agree to the use of anesthetics, sedative and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payment are not received by agreed upon dates, I understand that a 1 ½% late charge (18% APR) may be added to my account.

PATIENT: _____ DATE: _____
WITNESS:_____PARENT OR RESPONISBLE PARTY: _____
RELATIONSHIP TO PT: _____

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PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____
FIRST MI LAST

ADDRESS_____ CITY_____ ST_____ ZIP_____

E-MAIL_____ CELL #_____

HOME #_____ SS #_____ BIRTHDATE_____

CHECK APPROPRIATE BOX:

MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐

PATIENT'S/GUARDIAN'S EMPLOYER _____ WORK #_____

WORK ADDRESS _____ CITY _____ ST_____ ZIP_____

IF STUDENT:

NAME OF SCHOOL _____ CITY _____ ST_____

SPOUSE OR GUARDIAN:

NAME _____ PHONE # _____

EMPLOYER _____ WORK # _____

EMERGENY CONTACT:

NAME _____ PHONE # _____

How did you hear about us?

○ Friend: NAME_____ ○ Facebook ○ Google ○ Website

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE # _____

DRIVER LICENSE # _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK # _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

REGISTRATION