

Dental Insurance Information

Primary Insurance Co. _____ Telephone _____

Address _____ City/State _____ Zip _____

Employee _____ Date of Birth _____ Relationship to Patient _____

Policy holder

Employer (Name/Address) _____

Employee Social Security # _____ Group # _____

Secondary Insurance Co. _____ Telephone _____

Address _____ City/State _____ Zip _____

Employee _____ Date of Birth _____ Relationship to Patient _____

Employer (Name/Address) _____

Employee Social Security # _____ Group # _____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONSENT TO PROCEED:

Patient's Name _____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Mark L. Mangelson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or other therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: _____
(Patient, legal guardian or authorized agent of patient)

Date _____

Witness: _____

Date _____