

PATIENT INFORMATION
RONALD L. MORSE, D.D.S., P.C.

PATIENT:

NAME _____ HOME PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
SOCIAL SECURITY # _____ BIRTH ____/____/____ EMPLOYER _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
E-MAIL ADDRESS _____ BUSINESS PHONE _____
*IF MINOR, PARTY RESPONSIBLE FOR PAYMENT _____ SCHOOL _____

REFERRED BY: _____

SPOUSE / PARENT:

NAME _____
EMPLOYER _____ BUSINESS PHONE _____ EXT _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
OCCUPATION _____ YRS. WITH FIRM _____

INSURANCE:

NAME OF POLICY HOLDER _____
POLICY HOLDER'S DATE OF BIRTH ____/____/____ SOCIAL SECURITY # /ID# _____
NAME OF DENTAL INSURANCE COMPANY _____ GROUP # _____
ADDRESS _____ PHONE # _____
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT _____
IS THERE SECONDARY OR DUAL COVERAGE _____ NAME OF COMPANY _____
POLICY HOLDER _____
POLICY HOLDER'S BIRTHDAY ____/____/____ SOCIAL SECURITY # _____

TREATMENT AUTHORIZATION AND CONSENT

I consent to treatment as necessary or desirable for the diagnosis and treatment of dental disease, deformities, or treatment of a dental emergency including X-rays, models, medication, and other therapies. This authorization and consent for treatment will be made verbally after having a full explanation of the proposed treatment, alternatives, and risks. I understand that by the very nature of the proposed treatments and the uniqueness of myself as an individual that no one can predict the certainty of any outcome or success and that even in the event of treatment, my condition may worsen. I understand that no guarantee or assurances will be given to me for proposed treatment or alternatives.

I will feel free to ask questions about any proposed treatment, alternatives, and risks. I agree to abide by the doctor's or hygienist's post-operative instructions and understand that my failure to care for my oral health may lead to failure of treatment.

I understand that local anesthetics embody certain risks and I will discuss with the doctor my medical and health history indicating any serious problems and promise to inform the doctor and staff if any changes in my medical history occur.

I acknowledge full responsibility for payment of such service and agree to pay for them in full at the time of service unless other arrangements have been made. I further understand that a finance charge will be added after 60 days. If it becomes necessary to forward my account to a collection agency, in addition to the amount owed I will be responsible for the cost of collection. If I am a person 60 years or older, I understand there will be a 10% courtesy for payment in full with check or cash the day of dental treatment; If I am a person 59 years or younger, there will be a 5% courtesy for same day payment.

CANCELLATION/"NO SHOW" POLICY: A 24-hour notice is required to change or cancel any appointment. Regretfully, a \$50.00 charge will be assessed because it is impossible to fill the appointment.

Signed _____ Date _____