COHASSET VILLAGE DENTISTRY

Name: ______________________________ Preferred name: ____________________ Date: _____________

Date of Birth: ______________________ Age: ____ Social Security Number: _______________________

Gender: Male / Female / Other Marital Status: Married / Single / Divorced / Widowed

Address: ____

Phone: ____________________ (home/work/cell) Phone: ___________________________ (home/work/cell)

E-Mail:___________________________________ Employer: ____

Would you prefer **EMAIL**, **TEXT** or **BOTH** for appointment reminders and notifications?

Primary Dental Insurance

Insurance company:	Group number:
Employer:	
Employee:	Date of Birth:
Insurance ID:	Employee's SS#:
Insurance Address:	Insurance Phone Number:

Secondary Dental Insurance

Insurance company:	Group number:
Employer:	
Employee:	Date of Birth:
Insurance ID:	Employee's SS#:
Insurance Address:	Insurance Phone Number:

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Person financially responsible for the account if not self:

Name: ___________________________________ Relationship to patient: _______________________

Address: ______________________________________ Phone: ___________________ (home/work/cell)

Social Security #: ________________________________

How or by whom were you referred to our office?: ____

Emergency contact: _____________________________ Phone: _________________________

(home/work/cell)

Consent for Services

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to administer anesthetics or other medications as necessary, and to perform all recommended treatment mutually agreed upon by myself and the doctor.
2. I fully understand that dental treatment embodies certain risks. These risks include, but are not limited to: pain, infection, swelling, bleeding, post-operative sensitivity, prolonged numbness/tingling sensations, adverse reactions to injections, change in occlusion (bite), muscle discomfort, temporomandibular (jaw) joint discomfort, loosening of teeth or existing restorations, tissue damage, allergic reactions, bruising, and delayed healing. I understand that I can ask for a complete list of any possible complications specific to any recommended procedure.
3. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf. I am aware that although the staff at Cohasset Village Dentistry will file insurance claims if/when applicable as a courtesy to me, any balance not paid by my unique plan is ultimately my responsibility. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that a 1.5% monthly late charge may be added to my account.

Patient signature: ____ Date: _____________________

Parent or responsible party's signature: ____

Relationship to patient: ____