

Samuel B. Burg D.D.S.  
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Patient's Name \_\_\_\_\_ School \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone No. \_\_\_\_\_ Social Security \_\_\_\_\_

Residence – Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_ Cell # \_\_\_\_\_ email \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone No. \_\_\_\_\_ Social Security \_\_\_\_\_

Residence – Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_ Fax# \_\_\_\_\_ Cell # \_\_\_\_\_ email \_\_\_\_\_

Name person(s) Responsible for this account \_\_\_\_\_ Drivers License \_\_\_\_\_ Dad

Both parents  Guardians  Parent child lives with \_\_\_\_\_ Drivers License \_\_\_\_\_ Mom

Method of Payment:  Insurance and (or)  Cash  Credit Card  Care Credit

Purpose of Visit \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for your referral \_\_\_\_\_ Physician/Phone \_\_\_\_\_

Whom may we notify in case of emergency (not living in the home) \_\_\_\_\_ Ph# \_\_\_\_\_

Primary Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Living in the home? Yes  No

Address \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local / Group \_\_\_\_\_

Secondary Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Living in the home? Yes  No

Address \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local / Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. \_\_\_\_\_

My Consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I understand that I may incur an 1.5% service charge if my balance goes beyond 30 days. I attest to the accuracy of the information on this page.

PARENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_