



## Patient Information

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone (home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone (work): \_\_\_\_\_ Ext: \_\_\_\_\_

## Responsible Party Information

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other  
Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ Ext.: \_\_\_\_\_  
Address: (if different from above) \_\_\_\_\_

## Insurance Information

I do not have dental insurance

**Primary**  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insured's Address: (if different from above) \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Insurance Plan Name: \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Carrier Phone (Toll Free # on insurance card) \_\_\_\_\_

**Secondary** (Only necessary if you or your child are covered by more than one insurance plan)  
Patient's relationship to insured:  Self  Spouse  Child  Other  
Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insured's Address: (if different from above) \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Insurance Plan Name: \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Carrier Phone (Toll Free # on insurance card) \_\_\_\_\_

## Consent for Services

I authorize the staff of Rivertown Dental, P.C. to perform all forms of dental treatment, medication, and therapy that may be indicated. I accept all responsibility for payment on this account. I realize that payment is due as services are rendered unless other payment arrangements have been made in writing. I consent to treatment by the staff of Rivertown Dental, P.C.

\_\_\_\_\_  
Signature of patient, parent, or legal guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_