



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: _____