Ann Arbor Dental Care, PLLC Date

Patient Name_____ Birthdate_____ Sex: M F

Address_____ Apt/Lot Number _____

City_____ State_____ Zip_____ Single [ ] Married [ ] Other [ ]

Telephone Hm_____ Cell _____ Email: _____

Nearest Relative or Emergency
Contact name, address &
phone number : _____

_____ How did you
hear about us: _____

Party Responsible
For Account Self____ Spouse____ Parent____ Other_____ Sex: M F

Responsible
Party Name_____ D.O.B._____ Soc Sec No._____

Address_____ City_____ State_____ Zip_____

Telephone Hm_____ Cell _____ Email_____

Dental Insurance.
Name & Address_____

Subscriber Name_____ Birthdate_____ Sex: M F

Soc.Sec. No. or
ID Number_____ Group No_____ Relationship to Subscriber Self____ Spouse____ Dependent____

Dental Insurance Co.
Name & Address_____

Subscriber Name_____ Birthdate_____ Sex: M F

Soc.Sec. No. or
ID Number_____ Group No_____ Relationship to Subscriber Self____ Spouse____ Dependent____

I hereby authorize Ann Arbor Dental Care, PLLC to release any dental information which might be needed in connection with payment for dental services. I also request that payment under my dental insurance program be made directly to Ann Arbor Dental Care, PLLC on any bills for services rendered at this office. I understand that I am financially responsible to Ann Arbor Dental Care, PLLC for fees not covered by this authorization. This authorization remains valid until rescinded by me in writing. I have received the notice of privacy practices as per the HIPAA Privacy Rule.

Signature of patient, parent or guardian _____ Date_____

I hereby give consent to Ann Arbor Dental Care, PLLC and auxiliaries working under the dentist's supervision to perform those procedures and treatments including local anesthesia which are deemed necessary on:

Myself _____ My Son _____ My Daughter _____

I have been informed there are some risks inherent in all dental procedures. This includes the administration of local anesthesia and certain other drugs common to dental practice. I also understand I am free to ask any questions regarding the procedure and risk involved.

Signature of patient, parent or guardian _____ Date_____