JOHN T. GREEN, DDS, INC.

Patient Information:

Patient's Name______________________________
Patient's Address____________________________
City/State/Zip_______________________________
Home Phone #_______________________________
Cell Phone # _______________________________
Date of Birth________________________________
Social Security #_____________________________
Marital Status [ ] M [ ] S [ ] W [ ] D [ ] <age 18
Email Address_______________________________
Patient's Employer___________________________
Occupation__________________________________
Spouse/Guardian Name_______________________
Spouse/Guardian Address_____________________
City/State/Zip_______________________________
Home Phone # _______________________________
Cell Phone # ________________________________
Date of Birth________________________________
Social Security #_____________________________
Spouse/Guardian Employer____________________
Occupation__________________________________

Dental Insurance [ ] yes [ ] no

Primary Dental Insurance Information

Insurance Company_____________________
Insurance Address______________________
Insurance phone # ______________________
Subscriber's Name______________________
Patient's relationship to subscriber
[ ] self [ ] spouse [ ] dependent
Subscriber's Date of Birth_________________
Subscriber's SS# or ID#__________________
Group/Program_________________________

Secondary Dental Insurance Information

Insurance Company_______________________
Insurance Address________________________
Insurance phone # _______________________
Subscriber's Name________________________
Patient's relationship to subscriber
[ ] self [ ] spouse [ ] dependent
Subscriber's Date of Birth _________________
Subscriber's SS# or ID#___________________
Group/Program #_________________________

Getting to Know You

Is another member of your family a patient at our office?
Name____ Relationship____________________________
Person to contact for Emergency_______________ Phone #________________________________
Referred to us by____

Account Information

Person Financially Responsible for Account__________________________ Relationship_____________
Phone #____________________ Address____
City/State/Zip____

Consent for Treatment / Assignment / Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentists to release any information for this claim. I agree to be responsible for payment on all services rendered on my or my dependent's behalf. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event payments are not received within sixty days of service, I understand that 1 ½% interest charge (18%APR) will be applied to my account regardless of insurance payment status.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I hereby authorize doctor or designated staff to take x-rays, study models, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I certify that I have read or had read to me the contents of this form and fully understand the content.

Patient or responsible party signature

____ Date________________________