

Today's Date ____/____/____

Person Responsible for This Account

Last Name		First	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Divorced / Widow	
What do you prefer to be called?	Birth Date / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security	Driver's License
Street Address		City	State	Zip Code	E-mail Address	
Home Phone No. ()	Work Phone No. ()	Fax No. ()		Cell / Pager No. ()		
You Were Referred to Our Practice By (Please check one box)						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Internet <input type="checkbox"/> Radio Ad

Your Spouse

Last Name		First	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Divorced / Widow	
What do you prefer to be called?	Birth Date / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security	Driver's License
Street Address		City	State	Zip Code	E-mail Address	
Home Phone No. ()	Work Phone No. ()	Fax No. ()		Cell / Pager No. ()		

Employer Information

Your Employer			Spouse's Employer			
Street Address			Street Address			
City	State	Zip Code	City	State	Zip Code	
Phone No. ()	Extension ()		Phone No. ()	Extension		

Patient Information

Last Name		First	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Divorced / Widow	
What do you prefer to be called?	Birth Date / /		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security	Driver's License
Street Address		City	State	Zip Code	E-mail Address	
Home Phone No. ()	Work Phone No. ()	Fax No. ()		Cell / Pager No. ()		
Relationship to you	Relationship to Spouse		Student? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		School	

Consent for Treatment

I authorize Dr. McCulla and/or designated staff to take x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by Dr. McCulla to make a thorough diagnosis of (patient's name) _____'s dental needs.

Upon such diagnosis, I authorize Dr. McCulla 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 medications 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 agree to be responsible for payment of all services rendered on my behalf and of my dependents. I understand that payment is due prior to the time of service unless other financial arrangements have been made prior to treatment. In the event an overdue balance occurs, I understand that a Billing Charge of 1.5% of the outstanding balance will be added monthly to my account.

Signature (Patient, Parent or Guardian if Patient is a Minor)

Date