Welcome to Paul Hanna D.D.S.

1. PERSONAL INFORMATION

Patient Name:
Address:
City: State: Zip:
Home Phone Number:
Work Phone Number:
Mobile Phone Number:
Date of Birth: Male Female
Are you: Single Married Divorced Widowed Child
Social Security Number:
Are you: Employed Unemployed Student
Employer Name:
Occupation:
If the patient is a minor, please complete the boxes below.
Parent/Guardian:
School: Grade:

2. FINANCIAL RESPONSIBILITY

Name:
Relationship to Patient:
Address:
City: State: Zip:
Phone Number:

3. CONSENT FOR TREATMENT PLEASE READ AND SIGN

1. I hereby authorize the Doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids the Doctor deems appropriate to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the Doctor to perform all recommended treatment that I have agreed to receive and to employ such assistance as required to provide the highest quality care.
3. I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that the use of anesthetic agents embodies certain risks. I understand that I may ask for a complete explanation of any possible complications.
4. I understand there will be a $40.00 charge for any confirmed appointment cancelled within 24 hours of the appointment time.
5. I agree that I am responsible for payment on all services rendered on my behalf or my dependants.
6. I understand that payment is due at the time of service unless other arrangements have been made in advance. If there is a dental insurance claim being filed on my behalf I understand and agree to pay any and all estimated copays at the time any services are rendered. Any insurance claim filed that has not been paid after thirty days is my responsibility.

Patient: Date:

X _____
Patient/Parent/Guardian Signature

4. INSURANCE POLICY INFORMATION

Insurance Company:
Insurance ID:
Group Number:
Group Name:
Policy Holder:
Social Security Number:
Phone Number:

5. EMERGENCY CONTACT INFORMATION

Name:
Address:
Phone Number:

6. HOW DID YOU HEAR ABOUT OUR PRACTICE

7. PHARMACY INFORMATION

Name:
Address:
Phone Number:

8. EMAIL ADDRESSES