PATIENT INFORMATION

____ Date ______________________
Patient name Preferred Name

______________________ ______________________ ______________________
Date of Birth SSN Marital Status

____ ______________________
Address: Street Home Phone No.

____ ______________________
City State Zip Code Cell Phone No. (or Work)

INSURANCE INFORMATION

____
Name of Policy Holder SSN DOB

______________________ ______________________ ______________________
Insurance Co. Name Insurance Subscriber ID Insurance Group No.

Is the policy through an employer? ☐ Yes ☐ No Name of Employer:____________________________

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _________________

CONSENT FOR TREATMENT

Indicated by the signature below, consent for treatment is hereby granted to render any necessary dental, medical, and/or surgical treatment as Dr. Harmon deems necessary for the patient whose information is printed above. A parent or legal guardian, or an adult appointed by the parent/guardian, must accompany minor children for any appointment during which treatment is rendered. If the minor patient is accompanied by a representative for the parent/guardian, signed notification authorizing the representative to consent to treatment for the minor child is required.

____
Signature of patient, parent, or guardian Relationship to patient Date