PATIENT INFORMATION
RONALD L. MORSE, D.D.S., P.C

NAME_____ EMAIL:_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SS#_____ DATE OF BIRTH ____/____/____ EMERGENCY CONTACT NAME & PHONE:_____

EMPLOYER NAME_____ POSITION_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

REFERRED BY:_____

RESPONSIBLE PARTY: (if different from above)

NAME_____ HOME PHONE_____ CELL_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMAIL_____ SS#_____ DATE OF BIRTH ____/____/____

EMPLOYER NAME_____ POSITION_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

DENTAL INSURANCE:

POLICY HOLDER_____ POLICY HOLDER DOB____/____/____ POLICY HOLDER EMPLOYER_____

INSURANCE COMPANY_____ SS#/ID#_____ GROUP#_____ PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SECONDARY DENTAL INSURANCE:

POLICY HOLDER_____ POLICY HOLDER DOB ____/____/____ POLICY HOLDER EMPLOYER _____

NAME OF INSURANCE COMPANY_____ SS#/ID#_____ GROUP# _____ PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

TREATMENT AUTHORIZATION AND CONSENT

I consent to treatment as necessary or desirable for the diagnosis and treatment of dental disease, deformities, or dental emergency including X-rays, models, and other therapies. X-rays are recommended based on patient's individual needs but we require bite-wings at least every 3 years and full mouth x-rays every 5 years. This authorization and consent for treatment will be made verbally after having a full explanation of the proposed treatment, alternatives, and risks. I understand that by the very nature of the proposed treatments and the uniqueness of myself as an individual that no one can predict the certainty of any outcome or success and that even in the event of treatment, my condition may worsen. I understand that no guarantee or assurances will be given to me for proposed treatment or alternatives.

I will feel free to ask questions about any proposed treatment, alternatives and risks. I agree to abide by the doctor's or hygienist's post-operative instructions and understand that my failure to follow the instructions and care for my oral health may lead to failure of treatment. I understand that local anesthetics embody certain risks and I will discuss with the doctor my medical history indicating any serious problems and inform the doctor and/or staff if any changes in my medical history occur.

I acknowledge full responsibility for payment of such service and agree to pay for them in full at the time of service unless other arrangements have been made. I further understand that an 18% finance charge will be added after 60 days. If it becomes necessary to forward my account to a collection agency, in addition to the amount owed I may also be responsible for reasonable attorney fees and additional court costs. If I am a person 60 years or older, I understand there will be a 10% courtesy for same day cash or check payment. If I am a person 59 years or younger, there will be a 5% courtesy for same day cash or check payment. This is not applicable for patients with in-network insurance companies.
CANCELLATION/"NO SHOW" POLICY: A 24-hour notice is required to change or cancel any appointment. Regretfully, a $50.00 charge will be assessed because due to impossibility to fill the appointment.

Signed_____ Date_____