Patient Information:

Patient Name _____

Last First M

Person Responsible for Account – Please check one:

__Patient __ Spouse __Father __Mother __Guardian

Insurance Information:

PRIMARY INSURED (if no insurance, please complete for responsible party)

Name _____

Address _____

Home # _____ Work# _____ Cel# _____

Birthdate _____ Relationship to patient _____

Social Security number _____

Dental Insurance Company _____

Identification number _____ Group number _____

SECONDARY INSURED

Name _____

Address _____

Home # _____ Work# _____ Cel# _____

Birthdate _____ Relationship to patient _____

Social Security number _____

Dental Insurance Company _____

Identification number _____ Group number _____

EMERGENCY CONTACT

Name _____ Phone _____

AUTHORIZATION

I hereby authorize payment from my insurance company to Dr. Miloser otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that accounts over 30 days are subject to a 1.5% monthly finance charge (18%) per annum. I hereby authorize Dr. Miloser's office to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Dr. Miloser's office to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals.

Signature _____ Date _____