Sweet Tooth Dental

1850 W. Broadway
Idaho Falls, ID 83402

Medical Alert for Office Use

Thank you for visiting West River Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____

Address _____

_____

❑ Male
❑ Female

Employer _____ E-mail Address _____

Birth date _____ Referred By _____

Phone: Home (___) _____ Social Security # _____

Work (___) _____ May we contact you at work? ❑ No

Mobile(___) _____

Emergency: Name _____ Phone (___) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____

STREET CITY STATE ZIP

Telephone (___) _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE