

**WELCOME TO OUR OFFICE!**  
**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    (Last)                      (First)                      (Middle Initial)

Married: \_\_\_ Single: \_\_\_ Other: \_\_\_ Drivers License # (required for check payment) \_\_\_\_\_

If married, spouses legal name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #:(     ) \_\_\_\_\_ Work #:(     ) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #(     ) \_\_\_\_\_ Beeper #:(     ) \_\_\_\_\_ Fax:(     ) \_\_\_\_\_

**E-mail:** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Have any of your immediate family members been treated by this office? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of family member \_\_\_\_\_

Who is financially responsible for this account: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Whom may we thank for referring you to our office:** \_\_\_\_\_

**Insurance Patients:** Office Policy requires an insurance card and a completed insurance form with signature authorizing release of information and payment directly to our office for services rendered. Insurance is a patient's responsibility, however, our office will be glad to submit your claim if proper information is received at the time of the visit. We will apply any payment received from insurance company to your account. However, it is the patient's responsibility for any remaining balance. Please note that the insurance contract is between you and your insurance company. Any non - payment by the insurance company is the full responsibility of the patient within 45 days.

Insurance Carrier: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Social Security # \_\_\_\_\_ Birthdate: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING FORMS**

# Consent For Treatment

We are here to provide dental service to you in the most beneficial way possible. This requires mutual understanding. In order to educate and inform you, we would like you to read this consent for treatment.

I realize that unless I provide the doctor with an accurate and complete medical and dental history, complications may result. I am aware that the dentist may need to confer with my physician or take my blood pressure. I agree to provide all information. I will notify the office if there is any change in my medical status. \_\_\_\_\_ Initial

I understand that certain parts of my treatment may be performed by licensed, supervised paraprofessionals other than the dentist. I thus consent to treatment by those paraprofessionals.

I understand that x-rays, photographs or models of my mouth may be necessary for an accurate diagnosis and treatment. I understand that these are the property of the doctor, but that copies are available on request. I understand that a Fee will be charged for duplication of xrays or records. I consent to the use of these diagnostic tests unless I so state prior to their implementation. I hereby authorize Nottingham and Anenberg PA & Associates the use of my photos anonymously for display or diagnostic purposes.

I recognize that in cleaning teeth the dentist or paraprofessional may use a modern and efficient method known as ultrasonic cleaning. I understand that other electronic and mechanical devices will also be used in my treatment. I consent to such procedures unless I object to the use of such equipment in a timely fashion. I am aware that pacemakers are sensitive to some of this equipment and I will immediately inform all personnel if I have a pacemaker.

I realize that in the course of treatment, drugs and medications may be used. I realize that any risks concerned with drugs will be explained to me and if I have questions, I will ask. I know that occasionally a reaction may occur to these drugs or local anesthetics. I understand that some risks may be involved and that if I have any questions concerning their use, I should discuss this with the doctor. I realize that if I am experiencing any adverse reactions to drugs, medications or treatment, I should immediately advise the doctors or their assistants.

I understand that the doctor is not responsible for previously placed dental appliances or previous dental treatment. I understand that, in the course of treatment, these previously made dental appliances or other existing dentistry may need adjustment.

I know that I should listen carefully when the dentist advises me of any change in the plan of treatment which may result in adjustments of treatment, change in fee or time involved. I realize that alternative treatment plans will be discussed with me prior to my acceptance of treatment.

I agree that fees are payable when the service is rendered unless specific financial arrangements are made prior to dental treatment. Arrangements are made with the Treatment Coordinator.

I realize that guarantees of results or absolute satisfaction are not possible in dental health service. I realize that personal articles brought into the office are my responsibility.

I have read and understand the contents of these treatments and agree to the provisions of it. If I have any questions I will ask the doctor.

If cancellation is necessary, we appreciate 48 hour prior notice.

Signature of Parent or Guardian (for minor child) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank You.

Your cooperation, consent for treatment and open communication will greatly add to your dental success and it will make working toward our mutual goals much easier.

**CHARLES NOTTINGHAM, D.D.S., F.A.G.D.**  
**KENNETH ANENBERG, D.M.D.**