INSURANCE INFORMATION

Larry R. Goldstein, D.D.S.

Name of Insured/Policy Holder_____Telephone #:_____
Birthdate:_____Social Security #:_____FAX #:_____
Home Address:_____
City, State, Zip Code:_____

Insured's Employer:_____Telephone #:_____ext:____
Employer Address:_____
City, State, Zip Code:_____

GROUP NUMBER:**_____**Effective Date:_____
Employee Number:_____Date Employment Began:_____

Insurance Company:_____Telephone #:_____ ext:____
Claim Address:_____
City, State, Zip Code:_____

Your former address:_____
City, State, Zip Code:_____

Person to Contact for Emergency:_____Telephone #:_____
Address:_____ Relationship:_____
City, State, Zip Code:_____

Closest Relative not Living with you:_____Telephone #:_____
Address:_____
City, State, Zip Code:_____

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Goldstein or designated staff to take X-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Goldstein to make a thorough diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize Dr. Goldstein to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a 1.50% late charge (18.00% APR) may be added to my account.

Signature: Patient or Responsible Party: _____Date:_____
Witness: _____