Patient Name _____ Date _____

Address _____ City _____ Zip _____

Birthdate _____ Grade Level _____ Home Phone _____

Father's Name _____ Father's SS # _____

Father's Address & Phone (if different than child)_____

Father's Employer and Phone Number _____

Mother's Name _____ Mother's SS # _____

Mother's Address & Phone (if different than child) _____

Mother's Employer & Phone Number _____

Please list other family members we have seen:

Insurance Information

Insurance Company Name _____

Insurance Co. Phone # _____ Insurance Patient ID # _____

Insured Name _____ Relationship to Insured _____

Insured SS # _____ Group# _____

Insured Employer _____ Occupation _____

Employer Address City Zip

Physician's Name _____ Name of Former Dentist _____

How did you hear about our office?

Patient Consent

The undersigned hereby authorizes Dr. Logan's office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, therapy and medication that may be indicated and further authorize and consent that the doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility of dental services provided in this office for myself or my dependents is payable at the time services are rendered. I further understand that a 1 1/2% service charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees that may be required to collect.

X_____ Date _____

Parent/Guardian Signature