



THE MOGELOF DENTAL GROUP, LLC PATIENT / FAMILY INFORMATION

Patient #



PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	HOME PHONE
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER			OCCUPATION		
<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18							
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE
							OK TO CALL WORK INITIAL _____
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE
							OK TO CALL WORK INITIAL _____
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY _____							
RELATIONSHIP _____		WORK # _____		HOME # _____		CELL _____	
WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?							

FAMILY INFORMATION IF SAME AS ABOVE PLEASE CHECK HERE

LAST		FIRST	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS		STREET	APT#	CITY	STATE
		ZIP	HOME PHONE	WORK PHONE	

ASSIGNMENT & RELEASE

The undersigned hereby authorize The Mogelof Dental Group Doctors and staff to examine and to take X-Rays, Study Models, Photographs or use any diagnostic aids deemed appropriate by the doctor(s) to make a thorough diagnosis of the patients' needs. Upon such diagnosis, I authorize The Mogelof Dental Group Doctors to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the making of video tapes, photographs, and x-rays before, during and after treatment, and to the use of the same by the doctor(s) in scientific papers or demonstrations or lectures.

I authorize the release of treatment records as may be requested by insurance companies, health care professionals or directly to me, the patient, at my request.

I authorize any benefits from insurance carriers, otherwise payable to me, made payable directly to Mogelof Dental Group, LLC.

I will be responsible for all balances that exist on this patient account. In any proceeding to enforce the terms hereof, the prevailing party shall be entitled to recovery of reasonable attorney fees, in addition to any other costs of suit. As the admitting adult, I am responsible for the full settlement of this minor's account and I will be responsible for any reasonable collection and/or attorney's fee in the full settlement of this account. As the admitting adult, I authorize release of information or assignment of insurance benefits as stated above.

I am aware that I am responsible for rebilling charges applied to this account for late or non-response to monthly statements.

I am aware that I am responsible for a minimum charge of \$50 for each occurrence of failure to keep a confirmed appointment in this office without a minimum of 24 hours notice.

Signature _____ Date _____

