

**CONSENT:**

I understand that this examination is going to address my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
PATIENT NUMBER

**EMERGENCY RECORD**

© 2007 Wisconsin Dental Association  
(800) 243-4675

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

**DENTAL INSURANCE - 1ST COVERAGE**

MAILING ADDRESS \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

TELEPHONE: RES. \_\_\_\_\_ BUS. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CELL \_\_\_\_\_

TELEPHONE \_\_\_\_\_

PATIENT/PARENT EMPLOYED BY \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

**DENTAL INSURANCE - 2ND COVERAGE**

SPOUSE EMPLOYED BY \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

WHO IS RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

DRIVER'S LICENSE NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

METHOD OF PAYMENT: Insurance  Credit Card  Cash

TELEPHONE \_\_\_\_\_

PATIENT/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

SPOUSE/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

NAME AND TEL. NO. OF SOMEONE NOT LIVING WITH YOU TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_