Nidal S. Elias, D.D.S., M.S.

PATIENT ACQUAINTANCE FORM

PATIENT INFORMATION

PATIENT NAME: _____
Last First MI

Date of Birth: _____

Address: _____
Street **City** **State** **Zip Code**

Home Telephone: _____ **Business Telephone:** _____
Social Security No: _____ **Mobile Phone:**_____
Employer: _____
Employer Address: _____
Occupation: _____
Spouse Name: _____ **Business Telephone:** _____
Spouse Employer: _____ **Occupation:** _____
Whom May We Thank For Your Referral? _____

INSURANCE INFORMATION

DENTAL INSURANCE **MEDICAL INSURANCE**

Subscriber Name: _____ **Subscriber Name:** _____
Insurance Co: _____ **Insurance Co:** _____
Insurance Co. Address: _____ **Insurance Co. Address:** _____
_____ _____
Subscriber SSN: _____ **Subscriber SSN:** _____
Subscriber DOB:_____ **Subscriber DOB:**_____

Second Insurance Company Information (if applicable):
List Policy Holder Name, Insurance Co. Address, Telephone, Policy No, Group No.:
_____

CONSENT FOR TREATMENT

1. I hereby authorize the Doctor or designated Staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

2. Upon such diagnosis, I authorize the Doctor 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 medication 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 authorize my insurance benefits to be paid directly to the Doctor. I agree to be responsible for payment of all services on my behalf or my dependants. I understand that this Office does not accept responsibility for collecting an insurance claim or for negotiating disputed claims. I understand that payment is due at the time of service unless other arrangements have been made. I also understand insurance reimbursement is a contract between me and my insurance company. In the event that payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. In consideration of the services rendered to me by this dental office, I am obliged to pay said office in accordance with its credit terms and policy.

SIGNED: _____ **DATE:** _____