CARTWRIGHT DENTAL

Jeff Cartwright, DDS

1911 N Lebanon St,
Lebanon, IN 46052

Welcome! Please take a few minutes to fill out this form so that we may better assist you.

Name:_____ Sex: F M Date of Birth: _____

Contact information:

Phone:_____ Home Phone: _____

Email: _____

Address: _____

Preferred Contact Method? Call Text Email

Emergency contact: _____ Relationship: _____ Phone: _____

Who may we thank for inviting you? _____

Do you have any insurance we can file for you? Yes No

Occupation: _____ Employer: _____

Physician: _____ Location: _____ Phone: _____

Consent for Treatment:

The undersigned hereby authorizes Dr. Jeff and licensed team members to take radiographs, study models, photographs, or any other diagnostic aids necessary. I also authorize Dr. Jeff to perform any and all forms of treatment, medication, and therapy that may be indicated (we'll chat first). I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Cartwright Dental, and I am still fully responsible for all dental fees (we'll fight for you). These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to Cartwright Dental (unless we arrange otherwise). Any payments received by Cartwright Dental from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge may be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent of Child): _____ Date:_____

Witness:_____