GARY S. SOLNIT, D.D.S., M.S., F.A.C.D.

9675 Brighton Way, Suite 330

Beverly Hills, CA 90210

310-888-1850

PATIENT INFORMATION

PERSONAL INFORMATION

Date _____

Mr./Mrs./Ms/Miss/Dr. _____ Social Security ___/___/___ Birth Date ___/___/___ Age _____

Spouse's First Name _____ Home Phone # _____

If patient is a minor, please give parent's or guardian's name: _____ Daytime Phone # _____

Cell Phone # _____ Email Address _____

Home Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Driver's Lic. #: _____ State: _____

Employer: _____ Occupation: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in case of emergency: _____ Telephone #: _____

Special Interests or Hobbies: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

Name of Insured _____ Relationship with Patient _____ SS # _____

Is Insurance through employer or private? _____ Name of Carrier _____ Group # _____

Are you covered by a secondary insurance? _____ Name of Insured _____ Relationship to Patient _____

Is secondary Insurance through employer or private? _____ Name of Employer _____ SS # _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize 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 understand that I can ask for a complete recital of any possible complications. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. To avoid any misunderstandings regarding your dental insurance, we wish our patients to know ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We do not render services on the basis that the insurance companies will pay our fees. Our office will provide you with insurance receipts so that you can bill your own insurance company. We will be available to assist you in any way we can. **PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed-upon dates, In understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____