Michael K. Furumoto, DDS, Inc.

21308 Pathfinder Rd., Ste #111
Diamond Bar, CA 91765
Phone: (909) 861-3515

Responsible Party Information

Patient Name _____ Referred By _____

Insured Person's Name: _____

Social Security # (if different from health history form)_____ Insured's Birthdate: _____

Subscriber's ID Number: _____ Group Number: _____

Insurance Company: _____ Ins. Phone Number: _____

Secondary Insurance Information

Insured Person's Name: _____

Social Security #: _____ Insured's Birthdate: _____

Subscriber's ID Number: _____ Group Number: _____

Insurance Company: _____ Ins. Phone Number: _____

Person Responsible For Account: _____ Relationship to Patient: _____

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by name and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. 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.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18%APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ _____

Patient, (Parent or Agent if under 18) Date

Patient's Name: _____