Elysa P. Daniels, DDS, FAGD, PC
Blake J. Olson, DDS
P.O. Box 2268 – Carefree, AZ 85377
480-488-9735

Name:_____ Date:_____/_____/_____

Address:_____
(Number / Street) (City) (State) (Zip Code)

Occupation:_____ DOB:_____/_____/_____

Home Phone:_____ Cell Phone:_____

Emergency Contact:_____ Phone:_____

Previous Dentist:_____ Email:_____

Whom can we thank for referring you to our office:_____

Dental Insurance Information:

Policy Holder's Name:_____ DOB:_____/_____/_____

Social #: _____ Group #:_____

Employer:_____ Dental Ins. Phone: _____

Dental Ins. Mailing Address:_____

_____

_____

We are only providers for Delta Dental. For other insurance, as a service, we submit insurance claims for you and ask them to reimburse you.

Unless prior arrangements are made with our receptionist, we expect payment each time we provide treatment. This allows us to give you the best and most reasonable service possible without having to raise our fees. We appreciate your cooperation in this matter.

**Should you need any further information or clarification, the receptionist is happy to assist you.*

I fully understand and agree to the above policy and consent to treatment:

_____ _____
(Signature of patient or guardian) (Date)