

# AJEY VARMA D.D.S., P.L.L.C.

PRACTICE LIMITED TO PROSTHODONTICS

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TACOMA, WASHINGTON 98405  
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WWW.DRVARMA.COM

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Birth date \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Parent name \_\_\_\_\_ Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

Spouse employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency:

Relative to contact other than spouse or parent \_\_\_\_\_ Phone \_\_\_\_\_

Another person to contact other than relative \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you to this office \_\_\_\_\_ Phone \_\_\_\_\_

Insurance information: If you have NO insurance, check here \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Reason for this visit: Illness \_\_\_\_\_ Injury \_\_\_\_\_ Job related injury \_\_\_\_\_ Auto accident \_\_\_\_\_

Date of injury or onset of problem \_\_\_/\_\_\_/\_\_\_ Major complaint \_\_\_\_\_

If your injury is job related, complete the following:

Name of person who can authorize treatment \_\_\_\_\_ Title \_\_\_\_\_

Company's insurance carrier \_\_\_\_\_ Phone \_\_\_\_\_ Ok'd by \_\_\_\_\_

### Please sign and return to receptionist

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collection of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

CONSENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

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.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Lastly, 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, I understand that a 1% finance charge (12% APR) may be added to my account.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Patient or responsible party \_\_\_\_\_ Relationship to patient \_\_\_\_\_