# *Bucher Family Dentistry*

## *William E. Bucher, D.D.S  Ryan W. Bucher, D.D.S*

### PATIENT INFORMATION

**Patient Name: _____ MI: _____ Last Name:_____**

**Preferred Name:_____**

**Address: _____ City: _____**

**State: _____ Zip Code: _____**

**SS#:_____-_____-_____  DOB: _____-_____-_____  Sex**: __M __F

**Status**: __Single __Other __Married __Child

**Home Phone**: **_____ Cell**: **_____Work:_____**

**E-Mail Address**: **_____**

**Referral Information: __**Family __Internet __Yellow Pages __Another patient __Other

**Explanation**: **_____**

**Patient's Employer:_____ __ Occupation:_____ Title:_____**

**If patient is a student, name of school/college:_____ Year_____**

**Responsible Party Information:_____**

**Address: _____City: _____ State: _____ Zip Code: _____**

**Home Phone**: **_____ Work Phone**: **_____Cell**: **_____**

**Insured:_____ Employer:_____ Sex: __M __F**

**SS#: _____-_____-_____  DOB:_____-_____-_____**

**Dental Ins. Co: _____**

**Treatment Consent**

**I consent to treatment presented to me as diagnosed by Dr. Bucher. I understand that I am responsible for all charges. As a service to me, Bucher Family Dentistry will submit my dental claims for reimbursement. I accept responsibility for all charges not covered by the insurance plan and agree to make necessary arrangements in advance for my out of pocket expenses.**

**_____ Date:_____**
**Signature**

**_____ Date:_____ Relationship to patient: _____**
**Signature of patient, parent or guardian**