

PATIENT INFORMATION

DATE _____

NAME _____ MALE FEMALE | MINOR SINGLE MARRIED
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ OTHER _____

E-MAIL _____ BIRTHDATE _____ SS# _____ INS. ID _____

RESPONSIBLE PARTY (if someone other than the patient)

NAME _____ MALE FEMALE | MINOR SINGLE MARRIED
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ OTHER _____

E-MAIL _____ BIRTHDATE _____ SS# _____ INS. ID _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
LAST FIRST M

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ OTHER _____

INSURANCE INFORMATION

As a courtesy to our patients, we can file your dental insurance for you. If you would like to take advantage of this, please fill out the following portion of the form.

DENTAL INSURANCE:

EMPLOYER _____

GROUP # _____

INSURANCE COMPANY _____

INS. ADDRESS _____

CITY, STATE & ZIP _____

INS. PHONE _____

INSURED - IF OTHER THAN PATIENT:

NAME _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY, STATE & ZIP _____

HOME PHONE _____ OTHER _____

SS# _____ INS. ID _____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

X _____
Patient or Responsible Party Date

AUTHORIZATION

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professional by any method, including electronic transfer.

X _____
Patient or Responsible Party Date

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____