PATIENT INFORMATION

DATE_____/_____/_____

NAME _____ ❑ MRS. ❑ MS. ❑ MR. ❑ DR.
LAST FIRST M

NAME I PREFER TO BE CALLED: _____ ❑ FEMALE ❑ MALE ❑ MINOR

ADDRESS:_____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK # CELL #

E-MAIL ADDRESS _____ SS #_____ - _____ - _____

PLACE OF EMPLOYMENT _____

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

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ❑ YES ❑ NO NAME _____

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR A MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR AN ADULT.

FATHER (OR HUSBAND)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS#

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

Names and ages of your children:

_____

_____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

❑ Patient ❑ Father (or Husband)

❑ Guardian ❑ Mother (or Wife)

METHOD OF PAYMENT

❑ Payment in full at each appointment (cash or personal check)

❑ Payment in full at each appointment (❑ VISA ❑ MC ❑ DISCOVER)

Card # _____ Exp. Date _____

❑ I wish to discuss use of my dental insurance in this office.

❑ I wish to discuss available options of financial arrangement.

AUTHORIZATION

I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be nessessary 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 payors and/or other health professionals.

X _____

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

_____

Date State Driver's License #