

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)				MOTHER (OR WIFE)			
LAST		FIRST		LAST		FIRST	
STREET		CITY		STREET		CITY	
HOME TELEPHONE #		WORK TELEPHONE #		HOME TELEPHONE #		WORK TELEPHONE #	
BIRTH DATE (MO/DAY/YEAR)		SS#		BIRTH DATE (MO/DAY/YEAR)		SS#	
EMPLOYER				EMPLOYER			
DENTAL INSURANCE CO.		SUBSCRIBER#		DENTAL INSURANCE CO.		SUBSCRIBER#	
		GROUP#				GROUP#	

Names and ages of your children:

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.

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household
Name _____
Address _____
City/State/Zip _____
Telephone # _____

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 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 payors and/or other health professionals.

PERSON RESPONSIBLE FOR ACCOUNT

- Please Check One
- Patient Father (or Husband)
 - Guardian Mother (or Wife)

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

Date _____ State Driver's License # _____