

PATIENT INFORMATION

Date _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____ SS#: _____

ADDRESS: _____

<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> MINOR

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

←-----PLEASE CHECK WHICH NUMBER YOU PREFER US TO CALL TO CONFIRM APPOINTMENTS AND/OR LEAVE CONFIDENTIAL MESSAGES

PERSON RESPONSIBLE FOR ACCOUNT: PATIENT FATHER MOTHER SPOUSE GUARDIAN

INSURANCE INFORMATION

PRIMARY INSURED	
LAST	FIRST
ADDRESS	
HOME	WORK/CELL
DATE OF BIRTH	RELATIONSHIP TO PATIENT
EMPLOYER	DENTAL INS CO
SS#/ID#	INSURANCE PHONE #

SECONDARY INSURED	
LAST	FIRST
ADDRESS	
HOME	WORK/CELL
DATE OF BIRTH	RELATIONSHIP TO PATIENT
EMPLOYER	DENTAL INS CO
SS#/ID#	INSURANCE PHONE #

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

X _____
Signature of Responsible Party

_____ Date

EMERGENCY INFORMATION

NAME: (SOMEONE WITH A DIFFERENT PHONE NUMBER)

PHONE: _____

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 consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations. 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 professionals.

X _____
Signature of Responsible Party

_____ Date