PATIENT INFORMATION

Date _____

PATIENT NAME: _____

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

ADDRESS: _____

_____

☐MALE ☐FEMALE

☐SINGLE ☐MARRIED
☐WIDOWED ☐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

5713 Gray Road
Wesley Chapel, FL 33543
813.991.0097