

PATIENT INFORMATION

Whom may we thank for referring you? _____

Friend Relative Phonebook Dental Society Internet Other

Patient Information (Please Print and complete in full)

Name Mr. Mrs. Ms. Dr _____ Date of Birth: ___/___/___ Sex: M F

Social Security #: _____ E-mail : _____ Marital Status: S M W D

Home Address: _____
Street Apt.# City State Zip code

Home Phone #: _____ Cell Phone #: _____ Work Phone# _____

Patient's Employer: _____ Occupation: _____ How long employed? _____

Employer's Address: _____
Street Apt.# City State Zip code

Spouse's Name: _____ Date of Birth: ___/___/___ Social Security #: _____

Spouse's Employer: _____ Occupation: _____ How long employed? _____

Employer's Address: _____
Street Apt.# City State Zip code

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

SS#: _____ Date of Birth: ___/___/___ Home #: _____ Work # _____

Employer: _____ Address: _____

Plan Name: _____ Group #: _____ Individual Yearly Ded _____ Family Yearly Ded _____

Insurance Co. _____ Address: _____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

SS#: _____ Date of Birth: ___/___/___ Home #: _____ Work # _____

Employer: _____ Address: _____

Plan Name: _____ Group #: _____ Individual Yearly Ded _____ Family Yearly Ded _____

Insurance Co. _____ Address: _____

Emergency Contact Information

1.Name: _____ Phone # _____ Relationship _____

2.Name: _____ Phone # _____ Relationship _____

Primary Doctor's Name _____ Phone # _____

Consent

I, the undersigned hereby authorize the doctor to perform an exam, take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate. I further authorize the release of any information, including diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, or consulting professional. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Patient name (Please print) _____

Patient/Guardian Signature _____

Date _____