PATIENT INFORMATION

DATE_____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST MIDDLE

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____TELEPHONE _____
MONTH DAY YEAR HOME# WORK# E-MAIL

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

PRIMARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME # WORK# FAX# E-MAIL

BIRTHDATE(MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP#

FOR OFFICE USE

INSURANCE ADDRESS

INSURANCE PHONE# INSURANCE FAX#

MAX- UCR/FS

DED- P.

EFFECTIVE B.

PRE-AUTH M.

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for reffering you to our office?

_____

FOR OFFICE USE ONLY

METHOD OF PAYMENT

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

☐Payment in full at each appointment (□VISA □MC □OTHER)

Card#_____Exp.Date_____

☐I Wish to discuss the Dental Office's Financial Policy

AUTHORIZATION PLEASE SIGN

I hereby authorize payment directly to the Dental Office of the group insurance benefits. 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 maybe 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.

X_____
Patient or Responsible Party

_____
Date State Driver's License#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

Name_____

City/State/ZIP_____

Telephone #_____