PATIENT INFORMATION

NAME_____
LAST FIRST M PREFERRED NAME

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ MINOR ☐ MALE ☐ FEMALE BIRTHDATE_____

ADDRESS_____
STREET APT# CITY STATE ZIP

TELEPHONE_____ _____ _____
HOME# WORK# OTHER

PLACE OF EMPLOYMENT_____SOCIAL SECURITY#_____

IF FULL TIME STUDENT, SCHOOL NAME AND LOCATION_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____
NAME PHONE #

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

RESPONSIBLE PARTY INFORMATION

NAME OF PERSON RESPONSIBLE FOR ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____PHONE #_____

DRIVER'S LICENSE # _____ BIRTHDATE_____ EMPLOYER _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
NAME OF INSURED_____	NAME OF INSURED_____
DATE OF BIRTH_____ SS#_____	DATE OF BIRTH_____SS#_____
INSURANCE CO._____	INSURANCE CO._____
INS. CO. PHONE # _____	INS. CO. PHONE #_____
GROUP #_____	GROUP #_____
EMPLOYER _____	EMPLOYER _____

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTIONERS.

I AUTHORIZE AND HEREBY REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST (OR THE DENTAL GROUP) INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS.

_____ _____
SIGNATURE OF PATIENT OR PARENT IF MINOR DATE