PATIENT INFORMATION

Date:_____

NAME_____ **Married Single Minor Male Female**

Last First MI (Circle All That Apply)

ADDRESS:_____

Street Apt# City State Zip

BIRTHDATE: ___ - ___ - ___ **PHONE #:** _____*_____*_____*_____

Mo Day Year Home # Work # Cell # E-mail

PLACE OF EMPLOYMENT:_____ **SS#** ____ - ____ - _____

IF FULL TIME STUDENT, SCHOOL NAME: _____**GRADE:** _____

INSURANCE INFORMATION

PRIMARY INSURED

_____
Last First MI

_____
Street City/State/Zip

_____*_____*_____*_____
Home# Work # Cell# E-mail

_____
Birthdate (M/D/Y) Relationship to Patient

_____
Employer Insurance Company

_____
SS# Subscriber # Group/Policy#

SECONDARY INSURED

_____
Last First MI

_____
Street City/State/Zip

_____*_____*_____*_____
Home# Work # Cell# E-mail

_____
Birthdate (M/D/Y) Relationship to Patient

_____
Employer Insurance Company

_____
SS# Subscriber # Group/Policy#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

Name:_____

Address: _____

City/State/Zip: _____

Telephone #: _____

Has any member of you family ever been treated in our office:

___ Yes ___ No

Whom may we thank for referring you to our office:

_____

METHOD OF PAYMENT

Responsible Party currently has an account with this office ___ Yes ___ No

____ Payment in full at each appointment

____ Payment in full at each appointment. Visa, MC, Discover Card # _____ Exp Date:_____

____ I wish to discuss the Office's Financial Policy & Options

AUTHORIZATION

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 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