

PATIENT INFORMATION

Date _____ Social Security Number _____ Home Phone _____
Name _____ Birth Date _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Person to Contact in Case of Emergency _____ Phone _____
Nearest Relative Not Living With You _____ Phone _____
Whom May We Thank for Referring You _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Social Security # _____ Birth Date _____
Employer _____ Work Phone _____
Is this Person Currently a Patient in our Office? Yes No

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No
IF YES, COMPLETE THE FOLLOWING:
Name of Insured _____ Relation to Patient _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
Patient's Name _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefit 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 my dependents.

X _____
Signature of patient or parent if minor.