PATIENT INFORMATION

DATE: _____

NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT# CITY STATE ZIP

BIRTHDATE: _____/_____/_____ AGE: _____ TELEPHONE: (____) _____ (____) _____
HOME WORK

E-MAIL: _____ CELL PHONE: (____) _____

EMPLOYER (OR SCHOOL IF STUDENT): _____ OCCUPATION _____ S.S.# _____

ADDRESS: _____

DENTAL INSURANCE CO.: _____ GROUP NO. _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY ST ZIP	STREET CITY ST ZIP
Telephone:	HOME# WORK#	HOME# WORK#
Birthdate/SS #:	MO DAY YR SS#	MO DAY YR SS#
Employer:	EMPLOYER	EMPLOYER
Dental Insurance Co.: Group #:	DENTAL INSURANCE GROUP#	DENTAL INSURANCE GROUP#

PERSON RESPONSIBLE FOR ACCOUNT

NAME _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT OUTSIDE OF YOUR HOUSEHOLD

NAME _____ TEL# _____
LAST FIRST M

ADDRESS _____
STREET CITY STATE ZIP

AUTHORIZATION

- I hereby authorize and assign payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and I authorize this office to obtain my credit report, if necessary. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting my account.

- I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also authorize the provider to release any information required to process insurance claims. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

_____
STATE DRIVER'S LICENSE NUMBER

X _____ DATE _____

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian