

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST MI

MARRIED SINGLE MINOR

SOCIAL SECURITY # _____

MALE FEMALE

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

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

INSURANCE INFORMATION

MINOR CHILD : MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION

ADULTS: COMPLETE PRIMARY INSURED

DUAL COVERAGE: ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED				SECONDARY INSURED			
IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY							
LAST	FIRST	MI		LAST	FIRST	MI	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)				RELATIONSHIP TO PATIENT			
EMPLOYER				DENTAL INS. CO.			
SS#				SUBSCRIBER # GROUP #			

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/Zip _____

Telephone # _____

Has any member of your 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 (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

I hereby authorize 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. 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 _____

State Driver's License # _____