PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MALE ☐ FEMALE
LAST FIRST MI

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
HOME WORK

EMPLOYER _____ SS# _____

DENTAL INSURANCE CO _____

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

Seasonal Address, Phone No & dates out of this area

Street

City/State/Zip

Telephone # Dates out of area

Spouse Information

Last First M

Birth Date SS#

Employer Work Phone #

Dental Ins Co

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

☐ Patient ☐ Father (or Husband)

☐ Guardian ☐ Mother (or Wife)

METHOD OF PAYMENT

Payment in full at each appointment: Cash/Personal Check
Visa/MasterCard

AUTHORIZATION

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. 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.

SIGNATURE

DATE STATE DRIVER'S LICENSE #

DENTAL INSURANCE

I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

SIGNATURE