PATIENT INFORMATION (Please Print)

Name:_________________________________Name you prefer us to call you:_____________

Address:_____________________________City:_____________State:_______Zip:_______

Home #:(____)______________Work #:(____)______________Cell #:(____)____________

Date of Birth(DOB):_________Sex:___Social Security(SS)#:____________ # of Children:___

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

PERSON RESPONSIBLE FOR ACCOUNT (if other than self)

Name:__________________Relationship:_________________Driver's License #:__________

Address:_____________________________City:_____________State:_______Zip:_______

Employer:____________________ Occupation:_____________Social Security #:___________

IN CASE OF EMERGENCY CONTACT

Name:____Relationship:___________________

Home #:(____)______________Work #:(____)______________Cell #:(____)____________

WHOM MAY WE THANK FOR REFERRING YOU TO US?________________________________

DENTAL INSURANCE

Name of Insurance Company:_____________________Insurance Comp. Phone #:(___)________

Name of Insured:_____________________ Insured's Employer:__________________________

Insured SS #:__________________ Insured's DOB:__________ Relationship to Pt.:_________

AUTHORIZATION FOR INSURANCE

The undersigned patient, in requesting examination and/or treatment, authorizes the release of all information (including x-rays) relating to that examination or treatment to health service plans and insurance companies.

The undersigned patient also authorizes the release of such information to any peer review committee of state and local dental associations, which may request it.

I hereby authorize payment directly to the dentist named below of the group insurance benefits otherwise payable to me, but not to extend the actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Responsible Party

Signature:____Date:__________________

AUTHORIZATION FOR TREATMENT

After having discussed treatment with the dentist, I grant authority to the dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary, to include any x-rays.

Responsible Party

Signature:____Date:_____________