Patient Information

Date: _____

Name _____ ☐ Married ☐ Single ☐Male ☐ Female
Last First M

Social Security # _____

Address _____
Street Apt. # City State Zip

Birthdate _____ Telephone _____[_____
Month Day Year Home Work/Cell Email

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

Primary Insured / If No Insurance Complete For Responsible Party

_____
Last First M

_____
Street City State Zip

_____
Home Work / Cell Email

_____
Birthdate Relationship to Patient

_____
Employer Dental Insurance Co.

_____
SSN# Subscriber # Group #

Secondary Information

_____
Last First M

_____
Street City State Zip

_____
Home Work / Cell Email

_____
Birthdate Relationship to Patient

_____
Employer Dental Insurance Co.

_____
SSN# Subscriber # Group #

In Case Of Emergency

Name _____ City/State/Zip _____

Address _____ Telephone # _____

Has any member of your family ever been treated at our office? ☐Yes ☐ No

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

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 by any method, including electronic transfer.

X _____ **Date** _____
PATIENT SIGNATURE (PARENT OR GUARDIAN