PATIENT INFORMATION

First Name: ________________________ Last Name: ___________________________________ Middle Initial: ________

□ Married □ Single □ Divorced □ Widowed □ Male □ Female

Address: _____________________________________ City: _____________________ State: ________ Zip: __________

Birthdate: _______________ Social Security Number: _________________ Driver's License Number: __________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: _____________________

Email: ____ I would like to receive correspondences via Email □ Yes □ No

Person to contact in emergency: ________________________ Relationship: ____________ Phone: __________________

Has any member of your family ever been treated in our office? □ Yes □ No Name: ________________________________

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

PRIMARY DENTAL INSURANCE

Subscriber Name: ____ Relationship to Patient: ______________________

Address: _______________________________________ City: _________________ State: ________ Zip: ____________

Home Phone: ___________________________ Cell Phone: ______________________ Work Phone: ________________

Date of Birth: ____________________ SS#: _______________________ Employer: ______________________________

Insurance Company: ___________________________ Group #: ________________ Member ID #: __________________

Insurance Company Address: _____________________________________ Insurance phone: _______________________

SECONDARY DENTAL INSURANCE

Subscriber Name: ____ Relationship to Patient: ______________________

Address: _______________________________________ City: _________________ State: ________ Zip: ____________

Home Phone: ___________________________ Cell Phone: ______________________ Work Phone: ________________

Date of Birth: ____________________ SS#: _______________________ Employer: ______________________________

Insurance Company: ___________________________ Group #: ________________ Member ID #: __________________

Insurance Company Address: _____________________________________ Insurance phone: _______________________

AUTHORIZATION

I authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I do, however, understand that I am ultimately responsible for all costs of dental treatment. 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 and medical histories is correct to the best of my knowledge. I authorize the dentist to release my dental, medical, and treatment records to third party payers and/or other health professionals, as appropriately required. I understand it is my responsibility to inform this office of any changes in my medical status.

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Signed: □ Patient □ Parent □ Guardian Date