PATIENT INFORMATION

DATE_____

Last Name_____ First_____ MI_____

By what name do you wish to be called? _____ Date of Birth_____

Street Address_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex: M F Single ___ Married ___ Divorced ___ Widowed ___ SS#_____

Employer _____Occupation _____

Whom may we thank for referring you? _____

Is a relative or another member of your family a patient at our office?

Name_____Relationship_____

SPOUSE OR RESPONSIBLE PARTY (If patient is a minor)

Name_____ Relationship to Patient _____
Date of Birth _____ SS# _____
Home Phone _____Work Phone_____ Cell Phone _____
Address (if different than patient's) _____
Employer _____ Occupation _____

INSURANCE INFORMATION

Insured Name_____ Date of Birth_____
Insured SS #_____OR Insured ID#_____
Relationship to Patient_____ Employer_____
Dental Insurance Co_____ Group Number_____

Insured Name_____ Date of Birth_____
Insured SS#_____OR Insured ID#_____
Relationship to Patient_____Employer_____
Secondary Insurance Company_____ Group Number_____

I, the undersigned (patient or responsible party) authorize treatment to be rendered by the dentist & staff & assume full financial responsibility. I authorize the release of any information necessary for the filing of insurance claims & authorize payment directly to the dentist for benefits payable to me by the insurance company or administrator. I understand where appropriate, credit bureau reports may be obtained. This is valid until written notification from me.

Signature_____ Date_____