Date _____

PATIENT INFORMATION

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

Address _____
Street Apt. # City State Zip

Birthdate _____/_____/_____ Home Phone _____ E-Mail _____

Social Security # _____ Full time student _____
School

Patient Employer _____ Occupation _____

Business Address _____ Work Phone _____
Street City State Zip

Whom can we thank for referring you? _____ May we contact you at work? _____

FAMILY INFORMATION

Fill in both blocks for minor child or fill in appropriate block for adult.

Father (or husband)	Mother (or wife)
_____ Last First M	_____ Last First M
_____ Street City State Zip	_____ Street City State Zip
_____ Home Phone Birth Date SS#	_____ Home Phone Birth Date SS#
_____ Employer Work Phone	_____ Employer Work Phone

PRIMARY DENTAL INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Group # _____ Telephone # _____

Insured Name _____ Relation _____

SECONDARY DENTAL INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Group # _____ Telephone # _____

Insured Name _____ Relation _____

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.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household

Name _____

Address_____

City/State/ Zip_____

Telephone # _____