

PATIENT INFORMATION

DATE: _____

EMAIL: _____

NAME _____
LAST FIRST MPREFERRED NAME _____ MARRIED SINGLE MINOR MALE FEMALEADDRESS _____
STREET APT. # CITY STATE ZIPBIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK #

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, COLLEGE NAME _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO

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

FAMILY INFORMATION**FATHER (OR HUSBAND)**

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS #

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER (OR WIFE)

LAST FIRST M

STREET CITY STATE ZIP

HOME TELEPHONE # WORK TELEPHONE #

BIRTH DATE (MO/DAY/YEAR) SS #

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

**PERSON TO CONTACT
IN CASE OF EMERGENCY**

Outside of Immediate Family/Household

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

**PERSON RESPONSIBLE
FOR ACCOUNT**

Please Check One

 Patient Father (or Husband) Guardian Mother (or Wife)**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 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 _____
 Adult Patient Father (or Husband) Mother (or Wife) Guardian

_____ Date State Drivers License # _____