

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST M

MARRIED SINGLE MINOR

MALE FEMALE

SOCIAL SECURITY # _____ BIRTHDATE _____

ADDRESS _____
STREET APT# CITY STATE ZIP

TELEPHONE # _____
HOME WORK CELL

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

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

METHOD OF PAYMENT

PAYMENT IN FULL AT EACH APPOINTMENT (VISA MC AX) _____
CARD# EXP DATE

PAYMENT IN FULL AT EACH APPOINTMENT (CASH OR PERSONAL CHECK)

I WISH TO DISCUSS THE DENTAL OFFICE'S FINANCIAL POLICY

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

INSURANCE INFORMATION

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	SECONDARY INSURED
LAST FIRST M	LAST FIRST M
STREET CITY STATE/ZIP	STREET CITY STATE/ZIP
TEL: HOME WORK CELL	TEL: HOME WORK CELL
BIRTHDATE RELATIONSHIP TO PATIENT	BIRTHDATE RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO	EMPLOYER DENTAL INS. CO
DENTAL INS. CO. ADDRESS & TELEPHONE	DENTAL INS. CO. ADDRESS & TELEPHONE
SS# SUBSCRIBER# GROUP#	SS# SUBSCRIBER# GROUP#

AUTHORIZATION

I hereby authorize payment 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 _____
Patient or Responsible Party Date State Drivers License #

PERSON TO CONTACT IN CASE OF EMERGENCY

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

NAME _____ TELEPHONE # _____

ADDRESS _____ CITY/STATE/ZIP _____