PATIENT INFORMATION **DATE:_____**

NAME_____ Married Single Minor
First Last M _____ Female _____Male

ADDRESS_____ZIP_____
Street City State

BIRTH DATE_____ SS#_____PHONE#_____
WORK#_____

E-MAIL ADDRESS_____

IF FULL TIME STUDENT, SCHOOL NAME_____

PERSON RESPONSIBLE FOR THE ACCOUNT- circle one: patient guardian spouse father mother

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
Name	Name
Address	Address
Relationship to pt.	Relationship to pt.
Birth date	Birth date
Employer	Employer
SS # Group#	SS# Group#
Ins. co. name	Ins. co. name
Ins. co. addr	Ins co. addr
State Zip	State Zip

PERSON TO CONTACT IN CASE OF EMERGENCY
NAME_____
TELEPHONE #_____

Whom may we thank for referring you to our office? _____
Has any member of your family ever been treated in our office? □YES □ NO

AUTHORIZATION

I hereby authorize payment directly to the dentist of the group insurance payments otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I authorize the dental office to administer such medications and procedures that may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge. I grant the dentist the right to release my dental histories and other information to third party payors and/or other health professionals

METHOD OF PAYMMENT

PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR APPOINTMENT UNLESS A PAYMENT ARRANGEMENT HAS BEEN MADE PRIOR TO TODAY'S APPOINTMENT.

Signature_____ Date_____-
Drivers license #_____