Patient Information Last Name: _____ First Name: _____ Middle Initial: ___ Mr | Dr | Mrs | Miss | Ms Mailing Address: (Street, City, State, Zip) Birthday: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced Home Phone: _____ Work Phone: ____ Cell Phone: ____ Do you want text reminders? □ Yes □ No Email Address: _____ Do you want email reminders? Yes No SS#: _____ Drivers License Number: _____ Occupation: _____ Employer: _____ Employer Phone: ____ Employer Address: (Street, City, State, Zip) In Case of Emergency Contact Name: ______ Relationship: _____ Home Phone: ______ Work Phone: _____ Cell Phone: _____ Whom may we thank for referring you to us? **Account Information** □ Person responsible for this account is the same as above Last Name: _____ First Name: _____ Middle Initial: ___ Mr | Dr | Mrs | Miss | Ms Mailing Address: (Street, City, State, Zip) Birthday: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced Home Phone: _____ Cell Phone: _____ Email Address: _____ Do you want email reminders? \(\subseteq \text{Yes} \) \(\subseteq \text{No} \) Social Security Number: ______ Drivers License Number: _____ Occupation: Employer: Employer Phone: Employer Address: (Street, City, State, Zip) Insurance Company: ID Number: Group Number: □ Additional Insurance Mailing Address: (Street, City, State, Zip) □ Male □ Female □ Single □ Married □ Widowed □ Divorced Birthday: _____ Home Phone: _____ Cell Phone: _____ Email Address: Do you want email reminders? ☐ Yes ☐ No Social Security Number: ______ Drivers License Number: _____ Occupation: Employer: _____ Employer Phone: _____ Employer Address: (Street, City, State, Zip)

I do authorize and give consent to my Dentist and his Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the Dentist to release all information necessary to secure payment of benefits.

Insurance Company: _____ ID Number: _____ Group Number: _____

Patient or Responsible Party Signature: X ______ Date: ______