Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms

Mailing Address: (Street, City, State, Zio) _____

Birthday: _____ ☐ Male ☐ Femaile ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the telephone number you would like to be contacted first.

Email Address: _____

Social Security Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zio) _____

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

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom can we thank for referring you to us? _____

Responsible Party (Policy Holder) Information

☐ Person responsible for this account is the same as above

☐ Person above is a minor or not responsible for this account

Last Name: _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the telephone number you would like to be contacted first.

Email Address: _____

Social Security Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Secondary Dental Insurance

☐ I do not have secondary dental coverage. (Please skip this section)

Last Name: (Policy Holder) _____ First Name: _____ Middle Initial: _____ Mr I Dr I Mrs I Miss I Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Femaile ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the telephone number you would like to be contacted first.

Email Address: _____

Social Security Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

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

I do authorize and give consent to my Dentist and his/her 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 the use of anesthetic agents and dental treatments embodies certain risks.

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.

Patient or Responsible Party Signature: **X** _____ Date: _____