Patient information 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 Work Phone: Cell Phone: Please circle the telephone number you would like to be contacted first. Email Address: Social Security Number: _____ Employer: _____ Employer Phone: ____ Employer Address: (Street, City, State, Zip) _____ ID Number: _____ Group Number: _____ Insurance Company: _____ In Case of Emergency Contact _____ Relationship: Name: 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) ____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced Birthday: _____ Home Phone: _____ Work Phone: _____ _____ Cell Phone: _____ Please circle the telephone number you would like to be contacted first. Email Address: Social Security Number: ___ Employer: _____ Employer Phone: ____ Occupation: 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) ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced Birthday: _____ Home Phone: _____ Work Phone: ____ Cell Phone: Please circle the telephone number you would like to be contacted first. Email Address: Social Security Number: _____ Employer: _____ Employer Phone: _____ Employer Address: (Street, City, State, Zip) ID Number: ____ Group Number: Insurance Company: 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: _____