PATIENT INFORMATION

Whom may we thank for referring you?____

Name Mr. Mrs. Ms. Dr______________________________ **Date of Birth**:___/___/___ Sex: M F

Social Security #:__________-______**E-mail** :______________________**DL**#_____________ Marital Status: S M W D

Home Address:____
Street Apt.# City State Zip code

Home Phone #:_______________________ **Cell Phone** #:____________________ Work Phone#_____________________

Patient's Employer:__________________________ Occupation: ____________________ How long employed?_________

Employer's Address:____
Street Apt.# City State Zip code

Spouse's Name:___________________________________ Date of Birth:___/___/___ Social Security #:________________

Spouse's Employer:____________________________ Occupation: ____________________ How long employed?_______

Employer's Address:____
Street Apt.# City State Zip code

PRIMARY DENTAL INSURANCE

Subscriber Name:__________________________ Relationship to Patient:______________ ID #_____________________

Address:____
Street City State Zip code

SS#:_______________________ Date of Birth:___/___/___ Home #:___________________ Work #__________________

Employer:________________________________ Address_______________________________________
Street City State Zip code

Plan Name:_______________________________ ID #______________________ Group #:________________________

Address____
Street City State Zip code

SECONDARY DENTAL INSURANCE

Subscriber Name:_____________________________________ Relationship to Patient:_____________________________

Address:____
Street City State Zip code

SS#:_______________________ Date of Birth:___/___/___ Home #:___________________ Work #__________________

Employer:________________________________ Address:____

Plan Name:_______________________________ ID #______________________ Group #:________________________

Address____
Street City State Zip code

EMERGENCY CONTACT

1.Name:____ Phone #_____________________ Relationship ________________________

2.Name:____ Phone #_____________________ Relationship ________________________

Primary Doctor's Name____ Phone #____________________

I, the undersigned hereby authorize the doctor to perform an exam, take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate. I further authorize the release of any information, including diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, or consulting professional. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breech of this responsibility carries the penalty of compensating the practice any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I authorize to be contacted via cell phone (talk/text), and email regarding insurance, billing/collections and appointments.

________________________________ __________________________________ ______________
Patient name (Please print) Patient/Guardian Signature Date