

PATIENT INFORMATION (CONFIDENTIAL)

NAME (FIRST MI LAST) _____ DATE _____

PREFERRED NAME (IF APPLICABLE) _____ MALE [] FEMALE []

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL # _____ HOME # _____ WORK # _____

EMAIL _____ MINOR [] SINGLE [] MARRIED [] OTHER []

BIRTHDATE _____ SOC. SEC. # _____ DRIVER'S LICENSE # _____

EMPLOYER _____ MAY WE CONTACT YOU AT WORK? YES [] NO []

FAMILY MEMBERS WHO ARE PATIENTS HERE _____

WHOM MAY WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SOC. SEC. # _____ PHONE # _____

EMPLOYER _____ CURRENT PATIENT OF OURS? YES [] NO []

INSURANCE INFORMATION

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOC. SEC. # (REQUIRED TO FILE INSURANCE) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ INSURANCE COMPANY _____

GROUP # _____ MEMBER ID # _____ PROVIDER PHONE # _____

AUTHORIZATION

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

X _____

DATE _____
