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.

SIGNATURE ______________________________ DATE______________