PATIENT INFORMATION

DATE: _____

Name: _____

SSN: _____ Married_____ Single_____ Minor_____ Male_____ Female_____

ADDRESS: _____ _____
Street Apt#

_____
City State Zip Code

BIRTHDATE: _____ TELEPHONE: _____ _____
*May we text this number re: appointments? YES _____ NO _____

E-MAIL ADDRESS: _____ _____

NAME OF EMPLOYER: _____ _____Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: Patient____ Guardian____ Spouse____ Father____ Mother____

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Last	First	MI	Last	First	MI
Birthdate	SSN:		Birthdate	SSN:	
Employer			Employer		
Dental Insurance Company			Dental Insurance Company		
Subscriber #		Group #	Subscriber #		Group #

Who may we thank for referring you to our office? _____

Person to Contact in Case of an Emergency: _____
Name Phone Relationship

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 such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

_____
Patient Signature Date

_____
Guardian Signature Date