Patient Information

DATE_____

Patient Information

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Preferred Name _____

SEX: M F Marital Status _____ BIRTHDATE _____ AGE _____ SOCIAL SECURITY#_____ DRIVER'S LICENSE # _____

If Patient is a minor, give Parent's or Guardian's Name _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ WORK PHONE _____ ext _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____ EMAIL _____ NO. YEARS EMPLOYED _____

Who may we thank for referring you to our office _____ Reason for visit _____

Responsible Party Information

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Preferred Name _____

SEX: M F Marital Status _____ BIRTHDATE _____ AGE _____ SOCIAL SECURITY _____ DRIVER'S LICENSE # _____

If Patient is a minor, give Parent's or Guardian's Name _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ WORK PHONE _____ ext _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____ E-MAIL _____ NO. YEARS EMPLOYED _____

Responsible Party's Spouse

SPOUSE NAME Last _____ First _____ Middle Initial ____ Preferred Name _____

BIRTHDATE _____ AGE _____ SOCIAL SECURITY _____ DRIVER'S LICENSE # _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____ CELL PHONE _____ NO. YEARS EMPLOYED _____

Dental Insurance Information

INSURED'S NAME _____ SOCIAL SECURITY _____ BIRTHDATE _____

RELATIONSHIP OF PATIENT TO INSURED_____

INSURANCE Co. _____ GROUP PLAN _____ GROUP NUMBER _____

INSURED'S EMPLOYER _____ PHONE NUMBER _____ Ext _____

INSURANCE ADDRESS _____ City _____ STATE _____ ZIP _____

Patient Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

Patient Signature (Parent/Guardian of minor) _____ Date: _____ Dentist Signature_____

Acknowledgement of Receipt of Notice of Privacy

I, _____ acknowledge receipt of this office's Notice of Privacy Practices. (You may to refuse to sign this acknowledgment. Please notify staff if you refuse to sign.)