Patient information

Date ______________

Name ____________________ (Last / First / M) ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Social security # ____________________

Address ____________________ (Street / Apt. # / City / State / Zip)

Birthdate ___/___/___ (Month / Day / Year) ☐ E-mail ____________________

Please check preferred contact method

☐ Home phone ______________ ☐ Work phone ______________ ☐ Cell phone ______________

Name of employer ______________ Address ______________

If full time student, school name ______________ Grade ______

Person responsible for account - please check one: ☐ Patient ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

Insurance information

Minor child - may need to complete both blocks for parent information.
Adults - complete primary insured. Dual coverage? Also complete secondary insured

Primary insured

If no insurance complete for responsible party

Last / First / M

Street / City / State / Zip

Home / Work / Cell / E-mail

Birthdate (mo/day/year) / Relationship to patient

Employer / Dental insurance company

Ss # / Subscriber # / Group #

Secondary insured

Last / First / M

Street / City / State / Zip

Home / Work / Cell / E-mail

Birthdate (mo/day/year) / Relationship to patient

Employer / Dental insurance company

Ss # / Subscriber # / Group #

Person to contact in case of emergency

Name ______________

Relationship ______________

Address ______________

City/State/Zip ______________

Telephone ______________

Cell phone ______________

Has any member of your family ever been treated in our office?

☐ Yes ☐ no

Whom may we thank for referring you to our office?

____

Method of payment

Responsible party currently has an account with this office

☐ Yes ☐ no

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐visa ☐mc ☐other)

☐ I wish to discuss the dental office's financial policy

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 the right 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.

X ______________
Patient or responsible party

Date ______________ State drivers license # ______________

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