PATIENT INFORMATION

Name _____ ☐Married ☐Single ☐Minor ☐Male ☐Female

Last First MI

Social Security #_____ Today's Date_____

Address _____

Street City State Zip Code

Birthdate_____ E-mail_____

Telephone (home)_____ (cell)_____

(work)_____ (other)_____

Have you seen us on: *(check all that apply)* ☐ Facebook ☐ Twitter ☐ Google Reviews ☐ Billboard ☐ Local Magazine / Newspaper

Employer name and address_____

Person to contact in case of emergency: Name_____ Phone_____

How did you find us? ☐ referred by a friend: _____ ☐ other: _____

May we contact this person to thank them for your referral? **YES** **NO**

Dental Insurance Information

PRIMARY INSURED

_____ _____

Last name First name MI *Social Security number*

_____ _____

Date of Birth (Month/Day/Year) *Relationship to patient (self, father, mother, spouse, guardian)*

_____ _____

Employer of primary insured *Dental Insurance Company Name*

_____ _____

Subscriber # *Group #*

SECONDARY INSURED

_____ _____

Last name First name MI *Social Security number of secondary insured*

_____ _____

Date of Birth (Month/Day/Year) *Relationship to patient (self, father, mother, spouse, guardian)*

_____ _____

Employer of secondary insured *Dental Insurance Company Name*

_____ _____

Subscriber # *Group #*

I hereby authorize payment directly to Dr. Rita Tempel's office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment whether covered by the insurance plan or not. I authorize Dr. Tempel to administer medication and perform diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information listed above is 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.

_____ _____

Patient or responsible party signature *Date*