

# Welcome to Southridge Dental!

The benefits of a happy, healthy smile are immeasurable! Our goal is the help you reach and maintain maximum oral health. Please fill out the form completely. The better we communicate, the better we can care for you.

## Personal Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_ Male Female (circle one)  
Minor Single Married Divorced Widowed Separated (circle one)  
Address: \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email address \_\_\_\_\_ (For office use only)  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
How Long There? \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_ Other family members seen here? \_\_\_\_\_  
Previous dentist? \_\_\_\_\_ Last visit date? \_\_\_\_\_

## Responsible Party

His/Her name \_\_\_\_\_ Relationship to you \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work phone \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_  
(if different from patient address)

## Dental Insurance

<u>Primary Dental Insurance</u>	<u>Secondary Dental Insurance</u>
Insurance Company _____	Insurance Company _____
Address _____	Address _____
Insured _____	Insured _____
Birthdate _____ SS# _____	Birthdate _____ SS# _____
Employer _____	Employer _____
Policy or group # _____	Policy or group # _____

## Authorization and Release

*I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/ or health practitioners.*

*I authorize and request my insurance company to pay directly to the dentist insurance benefits other wise payable to me.*

*I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.*

\_\_\_\_\_  
Signature of patient (or parent if minor)

\_\_\_\_\_  
Date