



Please Complete the Following Confidential Information



**IF APPOINTMENT IS FOR YOU, START HERE**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Prefers to be Called By \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Mobile \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Married  Single  Divorced  Widowed

Social Security No. \_\_\_\_\_

**IF APPOINTMENT IS FOR YOUR CHILD, START HERE**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

School \_\_\_\_\_ Grade \_\_\_\_\_

Social Security No. \_\_\_\_\_

*If Your Child's Last Name and/or Address are Not the Same as Yours, Fill in the Top Box Also*



**GETTING TO KNOW YOU**

**Is another member of your family or relative a patient at our office?**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

**You were referred to us by** \_\_\_\_\_

**Your former address**

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Person to contact for emergency**

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Closest relative not living with you**

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



**DENTAL INSURANCE**

**PRIMARY CARRIER**

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Employer Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's I.D. No. \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_

**SECONDARY CARRIER**

Insurance Company \_\_\_\_\_

Group No. \_\_\_\_\_

Employer Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's I.D. No. \_\_\_\_\_

Insured's Social Security No. \_\_\_\_\_



**ACCOUNT INFORMATION**

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Social Security No. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**YOU**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**YOUR SPOUSE**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_



1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of \_\_\_\_\_'s dental needs.  
*(name of patient)*
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can inquire about possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made, and that I will be responsible for costs and attorneys fees if this is sent to collection.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible

Party's Signature \_\_\_\_\_ Relationship to Patient2 \_\_\_\_\_