

*Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care.
 To help us meet all your dental healthcare needs, please fill out this form
 completely in ink. If you have any questions or need assistance, please ask us -
 we will be happy to help.*

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____ Cell Phone _____

Position/Occupation _____ Birthplace _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Birthdate _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise 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 dependents.

Signature of patient or parent if minor _____