



Fill out and print the form below and bring it with you for your first visit.

Patient Name _____ Date of Birth _____ Gender: M or F

Parent Name _____

How do you wish to be addressed _____

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Address _____

City _____ State _____ Zip _____

Home Telephone # _____

Day Time Telephone # _____

Evening Telephone # _____

Cell Phone # _____

E-mail _____

Insured's address (if different from above: _____

City: _____ State: _____ Zip: _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ___ Cash ___ Credit Card ___

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you

Relative Name _____

Relative Number _____

Relative Relationship _____

PRIMARY INSURANCE

Employee Name _____ DOB: _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Program or policy No. _____

Social Security No. _____

Union Local or Group _____

SECONDARY INSURANCE

Employee Name _____ DOB: _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy No. _____

Social Security No. _____

Union Local or Group _____

RELEASE:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist use and disclosure of my records (or my child records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child records) to the following persons who are involved in my care (or my child care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT OR GUARDIAN SIGNATURE

DATE _____