

PATIENT INFORMATION

DATE: _____

NAME: _____ What would you like to be called? _____

ADDRESS: _____
STREET APT # CITY STATE ZIP

BIRTHDATE: _____ **TELEPHONE:** _____ **MARITAL STATUS:** _____
MO DAY YR HOME OR CELL WORK

EMAIL ADDRESS (we will not share): _____

PLACE OF EMPLOYMENT: _____ **OCCUPATION:** _____

BUSINESS ADDRESS: _____

DENTAL INSURANCE CO: _____ **GROUP #:** _____

SOCIAL SECURITY #: _____ **MEMBER ID #:** _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

HUSBAND or FATHER

WIFE or MOTHER

NAME:	_____	_____	_____	_____
	FIRST	LAST	FIRST	LAST
ADDRESS:	_____	_____	_____	_____
	STREET	CITY	STATE	STATE
TELEPHONE #s:	_____	_____	_____	_____
	HOME	CELL	HOME	CELL
BIRTHDATE/SSN #:	_____	_____	_____	_____
	MO DAY YR	SSN	MO DAY YR	SSN
EMPLOYER:	_____	_____	_____	_____
DENTAL INS CO:	_____	_____	_____	_____
		GROUP #		GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY _____
NAME PHONE #

AUTHORIZATION AND RELEASE – CONSENT FOR TREATMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Daniel Vincent if I, or my minor child, ever have a change in health.

I authorize my insurance company to assign directly to Dr. Daniel Vincent all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that payment is due at the time of services unless other arrangements have been made.

I hereby authorize Dr. Daniel Vincent or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my (or my child's) dental needs. Upon such diagnosis, I authorize Dr. Daniel Vincent to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

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 ask for a complete recital of any possible complications.

PARENT OR RESPONSIBLE PARTY: _____ **DATE:** _____