DENTAL PATIENT RECORD

PATIENT No. _____ ACCOUNT No _____ TYPE _____

Welcome to our office. We know you will be pleased with the care you will bee receiving. In order to begin treatment, the following information is necessary. Please complete fully and PRINT legibly. All information, of course, will be held in strict confidence. Thank you for joining our family of patients.

PATIENT HISTORY INFORMATION

PATIENT NAME: _____ HOME PHONE: _____

SOC. SEC. NO. _____ BIRTHDATE _____ AGE _____ SEX ___ MARITAL STATUS _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

SPOUSES'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____

STUDENT: ☐ FULL TIME ☐ PART TIME SCHOOL _____ CITY _____

WOMEN: ARE YOU PREGNANT ☐ YES ☐ NO HOW MANY MONTHS _____

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ☐ YES ☐ NO WHEN _____

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

SOC. SEC. No. _____ DRIVER'S LICENSE No. _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ YES ☐ NO

NAME _____ WHEN? _____

DENTAL INSURANCE: ☐ YES ☐ NO SECONDARY INSURANCE ☐ YES ☐ NO

INSURED'S NAME _____ INSURED'S NAME _____

SS# _____ BIRTHDAY _____ SS# _____ BIRTHDAY _____

EMPLOYER _____ EMPLOYER _____

INS. CO. or PLAN _____ INS. CO. or PLAN _____

UNION/GRP. NAME _____ UNION/GRP. NAME _____

GRP. or POLICY# _____ LOCAL# _____ GRP. or POLICY# _____ LOCAL# _____

DATE EMPLOYED _____ DATE EMPLOYED _____

HOW DID YOU HEAR ABOUT THIS OFFICE? FORMER PATIENT (WHO? _____)

☐ UNION ☐ TELEPHONE BOOK ☐ SAW BLDG./SIGN ☐ EMPLOYER

☐ ADVERTISMENT (WHICH? _____)

☐ OTHER _____

WHY ARE YOU HERE TODAY? _____

CHECK-UP, TOOTHACHE, CONSULTION, ETC.

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me.

_____ _____
PATIENT DATE

_____ _____
RESPONSIBLE PARTY DATE