Patient Information

Last Name: _____ First Name: _____ Middle Initial: ____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do you want text reminders? □ Yes □ No Email Address: _____

Do you want email reminders? □ Yes □ No SS#: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you to us? _____

Account Information

□ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: ____ Mr | Dr |Mrs | Miss |Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want email reminders? □ Yes □ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

□ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: ____ Mr | Dr |Mrs | Miss |Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ □ Male □ Female □ Single □ Married □ Widowed □ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want email reminders? □ Yes □ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

I do authorize and give consent to my Dentist and his Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the Dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____