



PATIENT INFORMATION

NAME OF PATIENT _____
First Middle Last Birthday Age

Resident Address _____
Street No. City State Zip

Mailing Address _____ Home Telephone No. _____

RESPONSIBLE PARTY

Father/Husband/Self _____ Mother/Wife/Self _____

Social Security # _____ Social Security # _____

Employer _____ Employer _____

Business Address _____ Business Address _____

Business Phone No. _____ Business Phone No. _____

Present Position _____ Present Position _____

How Long Held _____ How Long Held _____

In Case of Emergency - Person to contact (other than spouse) _____

Relationship _____ Phone # _____

Names and Ages of Children _____

Whom may we thank for referring you to our office _____

How do you intend to pay? Cash Check VISA MasterCard Discover Other

INSURANCE INFORMATION

Primary Insurance Co. _____

Insurance Co.'s Address _____

Subscriber _____ Relation to Patient _____

Employer _____ Date of Birth _____

Social Security # _____ Group # _____

Secondary Insurance Co. _____

Insurance Co.'s Address _____

Subscriber _____ Relation to Patient _____

Employer _____ Date of Birth _____

Social Security # _____ Group # _____

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 understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the record 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. I understand that payment or co-payment is due on the day of service.

X _____
Signature of Patient (Or Parent If Minor)

_____ Date