PATIENT INFORMATION (CONFIDENTIAL)

NAME:_____ DATE _____
     FIRST   MI   LAST

ADDRESS_____CITY_____STATE_____ZIP_____
EMAIL_____CELL PHONE_____HOME PHONE_____
SS#_____BIRTHDATE_____
MARRIED_____SINGLE_____DIVORCED_____CHILD_____
PATIENT OR PARENT'S/GUARDIAN'S EMPLOYER_____ WORK NUMBER_____
SPOUSE OR PARENT'S/GUARDIAN'S NAME_____ WORK NUMBER_____
WHOM MAY WE THANK FOR REFERRING YOU? _____

ALTERNATE CONTACT:
NAME_____ RELATION_____ PHONE NUMBER_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP_____
ADDRESS_____CITY_____STATE_____ZIP_____
DRIVER'S LICENSE#_____BIRTHDATE_____SS#_____
EMPLOYER_____WORK NUMBER_____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE☐   YES   ☐   NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP_____
BIRTHDATE_____SS#_____DATE EMPLOYED_____
NAME OF EMPLOYER_____WORK NUMBER_____
EMPLOYER ADDRESS _____CITY_____STATE_____ZIP_____
INSURANCE CO_____TELEPHONE# _____GROUP#_____ID#_____
INS CO ADDRESS_____CITY_____STATE_____ZIP_____

    DO YOU HAVE ADDITIONAL INSURANCE   ☐YES   ☐NO   IF YES COMPLETE THE FOLLOWING

NAME OF INSURED_____RELATIONSHIP_____
BIRTHDATE_____SS#_____DATE EMPLOYED_____
NAME OF EMPLOYER_____WORK NUMBER_____
EMPLOYER ADDRESS _____CITY_____STATE_____ZIP_____
INSURANCE CO_____TELEPHONE# _____GROUP#_____ID#_____
INS CO ADDRESS_____CITY_____STATE_____ZIP_____

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 RECORDS OF ANY TRREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CAERE TO THIRD PARTY PAYORS AND OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUPINSURANCE BENEFITS ORTHERWISE 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.

_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR