PATIENT INFORMATION

PLEASE TELL US ABOUT YOURSELF

Thank you for choosing our practice for your dental needs. We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete this form in ink. If you have any questions or need assistance, we will be happy to help!

PATIENT INFORMATION (CONFIDENTIAL):

TODAY'S DATE: _____

NAME: _____ LAST _____ FIRST _____ MIDDLE _____ PREFERRED NAME

_____ ADDRESS _____ CITY _____ STATE _____ ZIP

BIRTH DATE: ____/____/____ SSN: ____-____-____ SEX: ☐ FEMALE ☐ MALE ☐ _____

HOME PHONE: (____)____-____ WORK PHONE: (____)____-____ CELL PHONE: (____)____-____

EMAIL: _____

I PREFER TO BE CONTACTED VIA: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL ☐ NO PREFERENCE

EMPLOYER: _____

IF STUDENT, NAME OF SCHOOL: _____ CITY, STATE: _____ ☐ FULL TIME ☐ PART TIME

CONTACT IN CASE OF EMERGENCY: _____ PHONE: (____)____-____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

INSURANCE INFORMATION:

NAME: _____ LAST _____ FIRST RELATIONSHIP TO PATIENT: _____

BIRTH DATE: ____/____/____ SSN: ____-____-____

EMPLOYER: _____ WORK PHONE: (____)____-____ EXT: _____

EMPLOYER ADDRESS: _____ UNION OR LOCAL#: _____

INSURANCE COMPANY: _____ GROUP #: _____ POLICY/ID #: _____

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE: (____)____-____

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 authorize and request the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. 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

____/____/____ DATE