

PATIENT INFORMATION

Name _____ Cell Phone _____
Home Phone _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____
 Single Divorced Widowed Separated Married
Parent's/Spouse's Name _____

Person responsible for this account _____ Relationship _____
Home Address _____ City _____ State _____ Zip _____
Soc. Sec. # _____ Birth Date _____ Home Phone _____
Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE

Name of Insured _____ Birth Date _____ Soc. Sec. # _____
Home Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber ID _____ Group/Plan # _____

If you have additional dental insurance, please complete the following:

Name of Insured _____ Birth Date _____ Soc. Sec. # _____
Home Address _____ City _____ State _____ Zip _____
Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber ID _____ Group/Plan # _____

For an Emergency Contact _____ Phone _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the accompanying medical/dental history forms and information and the questions have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release to third party payers and/or health practitioners any information pertaining to the examination, diagnosis, and treatment rendered to me or to my child during the period of such dental care.

I authorize and request my insurance company to pay directly to the dentist the 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.

Date _____

X _____

Signature of patient
(parent if patient is a minor)