PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTH DATE _____ **TELEPHONE** _____
MONTH DAY YEAR HOME # WORK # CELL#

E-MAIL (FOR CONFIRMATION ONLY) _____

PLACE OF EMPLOYMENT _____ **SS#** _____

IF FULL-TIME STUDENT, SCHOOL NAME _____ **GRADE** _____

DENTAL INSURANCE CO. _____ **GROUP #** _____

Has any member of you family been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FATHER (OR HUSBAND)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

MOTHER (OR WIFE)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YR) SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One:

☐ Patient ☐ Father (or Husband)

☐ Guardian ☐ Mother (or Wife)

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, including any collection fees. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental treatment to third party payers and/or other health professionals.

X _____
☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

_____
Date State Driver's License #

METHOD OF PAYMENT

Responsible party currently has an account with this office.

☐ YES ☐ NO

☐ Payment in full at each appointment (cash or personal check)

☐ Payment if full at each appointment by credit card

☐ VISA ☐ MC

☐ Please see Office Financial Policy

A $50 FEE PER SCHEDULED HOUR, WILL BE CHARGED FOR APPOINTMENTS CANCELLED OR BROKEN WITH LESS THAN 48 HOURS NOTICE.. PLEASE NOTE YOU MUST SPEAK TO A STAFF MEMBER FOR THE FEE NOT TO APPLY