



**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST M  MARRIED  SINGLE  MINOR  MALE  FEMALE

SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT # CITY STATE ZIP

BIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER

**INSURANCE INFORMATION**

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS – COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME	WORK	CELL	E-MAIL	HOME	WORK	CELL	E-MAIL
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone \_\_\_\_\_

Has any member of your family been treated in our office?

Yes  No

Whom may we thank for referring you to our office?

\_\_\_\_\_

**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 cost of dental treatment. I hereby Authorize the Dental Office to administer such medications and perform such diagnostics, photographic 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/ medical histories and other information about my dental treatment To third party payors and/or other health professionals.

X \_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_ Date State Driver's License #