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 #

PLACE OF EMPLOYMENT _____ **SS #** _____

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

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

Has any member of your family ever been treated in our office? ☐ YES ☐ NO If yes, who? _____

How did you find out about our office? ____ Website ____ Friend Other _____

FAMILY INFORMATION FOR MINORS OR SPOUSE

☐ **FATHER** ☐ **HUSBAND** (Please check applicable box)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

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

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

☐ **MOTHER** ☐ **WIFE** (Please check applicable box)

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTH DATE (MO/DAY/YEAR) 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 ☐ Husband

☐ Guardian ☐ Mother ☐ 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. 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/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
☐ Adult Patient ☐ Father ☐ Mother ☐ 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 in full at each appointment by credit card
☐ VISA ☐ Mastercard ☐ DISCOVER

☐ I wish to discuss the Dental Office's Financial Policy