Patient Information:
Social Security #:_____Date:_____

Name:_____
Last Name First Name Middle Initial

Address:_____

City/State:_____ Zip Code:_____

Email Address:_____
Male / Female Birthdate:_____Age:_____
Married / Widowed / Single / Minor / Separated / Divorced

Occupation:_____
Patient Employer/School:_____
Employer/School Address:_____

Spouses Name:_____Birthdate:_____
Social Security #:_____Spouses Employer:_____

Whom may we thank for referring you?_____

Telephone Numbers:
Home:( )_____Work:( )_____Cell:( )_____
Spouses Work:( )_____Best time and place to reach you:_____

IN CASE OF EMERGENCY CONTACT: (specify someone who does not live in your household)
Name:_____Relationship_____
Home:( )_____Work:( )_____Cell:( )_____

Dental Insurance:
Who is responsible for this account?_____
Relationship to patient:_____
Insurance company:_____Group #_____
Is patient covered by additional insurance? Yes / No If yes:
Second Insurance company:_____Group#_____
Subscribers Name_____
Relationship to patient:_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for claims. I authorize that my records can be used by the doctor if he so determines in consideration of the services rendered to me by this office. I am obligated to pay said office in accordance with its credit terms and policies. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature:_____Date:_____