DATE ______

MR./MRS./MISS/MS.
(PLEASE CIRCLE ONE) LAST NAME FIRST NAME MI

HOME PHONE

CURRENT STREET ADDRESS

CELL PHONE / CARRIER ☐ PERMISSION TO TEXT?

CITY STATE ZIP

MAILING ADDRESS IF DIFFERENT

E-MAIL ADDRESS ☐ PERMISSION TO EMAIL?

MARITAL STATUS
(PLEASE CHECK ONE)
___ SINGLE
___ MARRIED
___ DIVORCED
___ SEPARATED
___ WIDOWED

PATIENT BIRTHDATE SOCIAL SECURITY NUMBER EMPLOYER (IF SELF EMPLOYED, PLEASE STATE NAME OF BUSINESS)

EMPLOYER ADDRESS (IF SELF EMPLOYED, EMPLOYER PHONE# POSITION HELD HOW LONG

EMERGENCY CONTACT :
NAME ______ RELATIONSHIP ______ CONTACT INFORMATION ______

PLEASE TELL US HOW YOU FOUND OUT ABOUT OUR OFFICE ______
IF PHONE BOOK WHICH ONE? ______

FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP

CURRENT STREET ADDRESS CITY STATE ZIP HOME PHONE

ARE OTHER FAMILY MEMBERS
PATIENTS IN OUR OFFICE? ___ YES ___ NO

SOCIAL SECURITY NO. WORK PHONE

DENTAL INSURANCE INFORMATION

INSURED PERSON'S FULL NAME (INCLUDING MIDDLE INITIAL) DATE OF BIRTH RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER INSURANCE COMPANY NAME GROUP NUMBER

UNION OR LOCAL NUMBER EMPLOYER NAME FULL ADDRESS OF EMPLOYER

DO YOU HAVE SECONDARY DENTAL COVERAGE ___ YES ___ NO (IF YES, COMPLETE THE FOLLOWING)

INSURED PERSON'S FULL NAME (INCLUDING MIDDLE INITIAL) DATE OF BIRTH RELATIONSHIP TO PATIENT

SOCIAL SECURITY NUMBER INSURANCE COMPANY NAME GROUP NUMBER

UNION OR LOCAL NUMBER EMPLOYER NAME FULL ADDRESS OR EMPLOYER

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care and further authorize and consent that the doctor chooses and employes such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office, including any portion not covered by insurance. We require 24 hours notice for any appointment change. After a missed appointment their may be a $45.00 Fee charge to your account. Thank you.

SIGNATURE OF RESPONSIBLE PARTY DATE

PATIENT INFORMATION