PATIENT INFORMATION

Who referred you to this office _____ Social Security # _____ Date _____

Patient's Name _____ Birthdate _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ **Email** _____

Employer _____ City _____ Occupation _____

Name of Parent/Partner/Spouse/Guardian _____ Birthdate _____
(Circle one)
Address if different _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Employer _____ City _____

- In case of emergency, whom shall we notify?

Name _____ Relationship _____ Phone _____

I° DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

2° DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

GROUP / POLICY # _____

SUBSCRIBER # _____

BIRTHDATE _____

Patient Acknowledgments:

- I understand that all charges incurred are payable in full at the time of service
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above : Signature _____ Date _____
Parent or Guardian if a minor