

PATIENT INFORMATION

DATE: _____

NAME: _____ DR. MR. MRS. MS.
LAST FIRST MIDDLE

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____
MO - DAY - YEAR HOME WORK CELL

EMAIL ADDRESS: _____

Please circle the ways you would like to be contacted about your appointments: phone call email text message

EMPLOYER NAME: _____ ADDRESS: _____ POSITION: _____

DRIVER'S LICENSE #: _____ STATE: _____ SS#: _____

DENTAL INSURANCE CO: _____ GROUP NO.: _____

Has any member of your family ever been treated in our office YES NO How did you hear about our office? _____

FAMILY INFORMATION

SPOUSE / SIGNIFICANT OTHER				PARENT / GUARDIAN (if child)			
LAST	FIRST	MI		LAST	FIRST	MI	
STREET		APT.#		STREET		APT.#	
CITY		STATE	ZIP	CITY		STATE	ZIP
HOME #		WORK #		HOME #		WORK #	
MO	DAY	YEAR	SS#	MO	DAY	YEAR	SS#
DRIVER'S LICENSE #				DRIVER'S LICENSE #			
EMPLOYER	ADDRESS		POSITION	EMPLOYER	ADDRESS		POSITION
DENTAL INSURANCE			GROUP #	DENTAL INSURANCE			GROUP #

PERSON RESPONSIBLE FOR ACCOUNT Check One: Patient Father/Husband Mother/Wife Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY Name (last, first): _____ Tel#: _____
Address: _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

- Payment in full at each appointment.
- Monthly budget payments (must complete credit application).

Does Responsible Party currently have an account with this office? YES NO

AUTHORIZATION

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 medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X _____

Relationship to Patient: _____