Patient Name_____ Date of Birth_____ ☐ M ☐ F
How do you wish to be addressed? _____ SSN _____
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Minor ☐ Widowed
If child, parent's name_____

Address _____ City, State _____ Zip _____
Home Phone_____ Work Phone _____
Cell Phone _____ Email Address _____
Who is responsible for this account? _____ Relationship to patient_____
Patient Employer _____
Other family members in this practice _____
Whom may we thank for referring you to this office? _____

Emergency Contact Name _____ Phone Number _____
Relationship to Patient _____

Dental Insurance
Policy Holder Name _____ Employer Name _____
Policy Holder Date of Birth_____ ID Number (or SSN) _____
Name of Insurance Company_____ Phone Number _____
Group Number _____

Dental Insurance (If Secondary Policy)
Policy Holder Name _____Employer Name _____
Policy Holder Date of Birth_____ ID Number (or SSN) _____
Name of Insurance Company _____ Phone Number _____
Group Number _____

Consent
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my children's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I Understand that my insurance carrier of my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts.
I certify that I have read and understand the above information to the best of my knowledge.

_____ _____
Patient or Guardian's signature Date