

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ INITIAL: \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_ DOB \_\_\_\_\_

( Single  Married  Divorced) ( Male  Female) Full time Student?  Yes  No School \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_ Group \_\_\_\_\_

Is patient covered by another dental insurance?  Yes  No Insurance Co. \_\_\_\_\_

How did you hear about our practice? Whom may we thank for your referral? \_\_\_\_\_

**HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_ Group \_\_\_\_\_

**WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_ Group \_\_\_\_\_

**NEAREST RELATIVE**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

**AUTHORIZATION**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature \_\_\_\_\_ Date \_\_\_\_\_