



Last Name: _____
First Name: _____ MI: _____
Date of Birth: ____/____/____ Male Female
If child, Parent's Name: _____

CONTACT INFORMATION

Residence Phone: (____) _____ - _____
Business Phone: (____) _____ - _____
Mobile Phone: (____) _____ - _____
Email: _____

HOME ADDRESS

Street: _____
City: _____ ST: ____ Zip: _____

BUSINESS INFORMATION

Employer: _____
Address: _____
City: _____ ST: ____ Zip: _____
Present Position: _____
Length of Employment: _____
Person Responsible for Account: _____

EMERGENCY CONTACT

Name: _____
Residence Phone: (____) _____ - _____
Business Phone: (____) _____ - _____
Mobile Phone: (____) _____ - _____

REFERRAL INFORMATION

Purpose of Visit: _____
Other Family Members Cared for by Practice:

How did you hear about this practice?

Name of referral:

DENTAL INSURANCE

First Coverage

Employee Name: _____
Date of Birth: ____/____/____
Employer Name: _____
Length of Employment: _____
Name of Insurer: _____
Insurer Address: _____
City: _____ ST: ____ Zip: _____
Phone: (____) _____ - _____
Program/Policy #: _____
Social Security #: _____
Union Local/Group: _____

Second Coverage

Employee Name: _____
Date of Birth: ____/____/____
Employer Name: _____
Length of Employment: _____
Name of Insurer: _____
Insurer Address: _____
City: _____ ST: ____ Zip: _____
Phone: (____) _____ - _____
Program/Policy #: _____
Social Security #: _____
Union Local/Group: _____

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 child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment and payments.

My consent to disclosure of records shall be effective until I revoke it in writing. I understand that my dental care insurance carrier or payor 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 attest to the accuracy of the information on this page.

(Patient Signature)

(Date Signed)