Patient Information

Name: _____ Date_____
First Last M

SS#_____ Birthday_____ ☐ Married ☐ Single ☐ Male ☐ Female

Address_____
Street Apt# City State Zip

Home Phone_____ Cell _____ Work_____

Place of Employment _____

Spouse Name _____Birthday_____ Spouse Employer_____

Cell phone_____ Work Phone_____ SS#_____

Minors Only

Resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____

FATHER_____ Father's Birthday_____ SS#_____

Address (if different) _____ Cell Phone: _____

Place of Employment_____ Work Phone:_____

MOTHER_____ Mother's Birthday_____ SS#_____

Address (if different) _____ Cell Phone: _____

Place of Employment_____ Work Phone:_____

Other_____ Birthday_____ SS#_____

Address (if different) _____ Cell Phone: _____

Place of Employment_____ Relationship to Minor_____ Work Phone:_____

Dental Insurance

Primary Policy Holder:_____ Name of Insurance Company: _____

Secondary Policy Holder:_____ Name of Insurance Company: _____

Alternate Contact

OUTSIDE OF FAMILY HOUSEHOLD

Name_____ Relationship _____

Home Phone_____ Cell _____ Work _____

I hereby authorize directly to the Dental Office of the group insurance benefits otherwise payable to me. 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, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____ Date_____
Patient or Responsibly Party Signature