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PATIENT INFORMATION
(Please Print)

CONFIDENTIAL

DATE _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check One: _____ Minor _____ Single _____ Married _____ Divorced _____ Widowed

Patient's Employer _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Lives With _____ (if patient is a minor)

If patient is a minor: Mother Name _____ Day Phone or Cell _____

Father Name _____ Day Phone or Cell _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible _____ Relationship to patient _____

Address _____ Home Phone _____

Social Security Number (required) _____ Date of Birth (required) _____

Is this person a current patient in our office? _____Yes _____ No

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Name of Employer _____ Insurance Company _____

Group Number _____ Subscriber ID Number _____

Do you have additional dental insurance: _____Yes _____ No. If yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Name of Employer _____ Insurance Company _____

Group Number _____ Subscriber ID Number _____

This is to certify that I, the undersigned consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary and advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all costs incurred in the collection of those fees. I also state the information given by me on this form is correct.

Signature _____ Date _____
Patient, Parent or Guardian