welcome

Patient Number | | | | | | | Date _____

Patient Information

Name _____

Age _____ Date of Birth _____ Male Female

Single Married Separated Divorced Widowed Minor

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____ Email _____

Social Security Number _____

Drivers License Number _____

Work Place _____

Position _____

Work Address _____

City _____ State _____ Zip _____

Work Phone _____

Spouse, Parent or Guardian Information

Relation: Spouse Parent Guardian

Name _____

Social Security Number _____

Work Place _____ Years _____

Position _____

Work Address _____

City _____ State _____ Zip _____

Work Phone _____

Emergency Contact

Emergency Contact _____

Phone _____ Relation _____

Other Information

Referral? Yes No If yes, who? _____

Purpose of Visit _____

_____

Information Disclosure

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

Name _____ Relation _____

Name _____ Relation _____

Dental Insurance - 1st Coverage

Information Same as: Patient Spouse Parent Guardian

Employee Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____ Years _____

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Policy Number _____ Group Number _____

Dental Insurance - 2nd Coverage

Information Same as: Patient Spouse Parent Guardian

Employee Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____ Years _____

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____

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

____ My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance 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, and that I am financially responsible for payment in full of all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of all services not paid, by my dental care provider.

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

Signature _____ Date _____

Print Name _____