Preferred Name______________________

CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE: _____/_____/________

NAME Last ____ First _______________________ Middle ____________________ SEX: M F

STREET ADDRESS ____ City _________________________ State _______ Zip __________

MAILING ADDRESS ____ City _________________________ State _______ Zip __________

SOCIAL SECURITY # _______-______-________ BIRTHDATE ______/______/_________ AGE ______ DRIVERS LICENSE # ____________________________

EMPLOYER ____ OCCUPATION __________________________________ YEARS EMPLOYED _______

PHONE Home (_______) ________-___________ Work (_______) ________-___________ Cell (_______)________-___________ MARRIED? YES NO

EMAIL ADDRESS ____

PREFERRED METHOD OF CONTACT (circle one) Home Phone Cell Phone Work Phone Email Text Messages Other ___________________

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____________________

NAME Last ____ First _______________________ Middle ____________________ SEX: M F

ADDRESS ____ City _________________________ State _______ Zip __________

SOCIAL SECURITY # _______-______-________ BIRTHDATE ______/______/_________ AGE ______ DRIVERS LICENSE # ____________________________

EMPLOYER ____ OCCUPATION __________________________________ YEARS EMPLOYED _______

PHONE Home (_______) ________-___________ Work (_______) ________-___________ Cell (_______)________-___________ MARRIED? YES NO

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)	SECONDARY DENTAL INSURANCE INFORMATION
INSURED'S NAME ____________________________	INSURED'S NAME ____________________________
INSURANCE COMPANY __________________________	INSURANCE COMPANY __________________________
INS. CO. ADDRESS ____________________________	INS. CO. ADDRESS ____________________________
CITY ____________________ ST ________ ZIP ____________	CITY ____________________ ST ________ ZIP ____________
INSURED'S EMPLOYER __________________________	INSURED'S EMPLOYER __________________________
INSURED'S BIRTHDATE _______/_______/____________	INSURED'S BIRTHDATE _______/_______/____________
INSURED'S SSN# _______/_______/__________ID# ______________	INSURED'S SSN# _______/_______/__________ID# ______________
GROUP # __________________ LOCAL # ______________	GROUP # __________________ LOCAL # ______________
-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-	-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: ___________________________________RELATIONSHIP TO PATIENT: ________________________

HOME PHONE # (______) ______ - __________ WORK # (______) ______ - __________ CELL # (______) ______ - __________

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the Doctor may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) ____ DATE ____ / ____ / _______