PATIENT INFORMATION

NAME: _____ ❒ MARRIED ❒ SINGLE ❒ MINOR ❒ MALE ❒ FEMALE
Last First Middle

ADDRESS: _____
No. Street City Stale Zip

BIRTH DATE: _____ TELEPHONE: _____ WORK: _____
Home Business

EMPLOYER (OR SCHOOL): _____ S.S.# _____
Patient's

Has any member of your family ever been treated in our office? ❒ YES ❒ NO NAME: _____

Parents name if patient is under 18: _____

INSURANCE INFORMATION

Insurance Company Name: _____ Insurance Group #: _____

Address: _____
Street City Stale Zip

Telephone #: _____ Employee Name _____

EMPLOYER/EMPLOYEE INFORMATION

Employee's Name: _____ Birth Date: _____ SS#: _____
Last First Middle

Employee's Address (if different from Patient): _____
Street City Stale Zip

Employer's Name: _____

Employer's Address: _____ Employer's Phone: _____
Street City Stale Zip

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE: ❒ Patient ❒ Father (or Husband) ❒ Mother (or Wife) ❒ Guardian

Name: _____ Address: _____
Street City Stale Zip

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: _____ TEL# _____ Address: _____
Street City Stale Zip

AUTHORIZATION

I hereby authorize payment 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 and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X _____ DATE _____

❒ Patient ❒ Father (or Husband) ❒ Mother (or Wife) ❒ Guardian