

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) \_\_\_\_\_

Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No

Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: (Street, City, State, Zip) \_\_\_\_\_

## In Case of Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Whom can we thank for referring you to us? \_\_\_\_\_

## Account Information

Person responsible for this account is the same as above

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) \_\_\_\_\_

Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No

Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: (Street, City, State, Zip) \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Additional Insurance

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) \_\_\_\_\_

Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No

Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: (Street, City, State, Zip) \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_