

Welcome to our office! The information requested on this and the following pages is necessary for your treatment. Our records are kept strictly confidential. Thank you for your thoroughness and honesty in answering these questions.

NAME (Mr./Mrs./Dr./Ms./Miss) \_\_\_\_\_  
last first m.i.

ADDRESS \_\_\_\_\_  
street apt. #  
city state zip

PHONE Home (\_\_\_\_\_) \_\_\_\_\_ Office (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Where shall we contact you to confirm your appointments? HOME OFFICE CELL OTHER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

ADDRESS OF RESPONSIBLE PERSON \_\_\_\_\_

MARITAL STATUS M S D W SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S OCCUPATION \_\_\_\_\_ SPOUSE'S EMPLOYER \_\_\_\_\_

SPOUSE'S BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_ SPOUSE'S CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

**DENTAL INSURANCE**

Primary Coverage \_\_\_\_\_ Employee Name \_\_\_\_\_

Employee S.S.N. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group # \_\_\_\_\_ Empl. I.D. # \_\_\_\_\_

Secondary Coverage \_\_\_\_\_ Employee Name \_\_\_\_\_

Employee S.S.N. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Group # \_\_\_\_\_ Empl. I.D. # \_\_\_\_\_

**EMERGENCY NOTIFICATION**

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Off. (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**CONSENT**

I, the undersigned, hereby authorize Doctor or his agents to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of Patient's dental needs. I also authorize Doctor or his agents to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event that credit is extended, I authorize this office to check my credit history. I understand that if my account is 90 days past due, I will incur a service charge of 1% (one percent) monthly until the balance is paid. In the event of default on my account, I promise to pay this interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT INFORMATION**