DENTAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

DATE ____________

PATIENT'S LAST NAME ____ FIRST NAME ____ M ____ CELL ____ ( ) HOME PHONE ____

CURRENT STREET ADDRESS ____ CITY ____ STATE ____ ZIP ____ HOW LONG? ____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS) ____

PATIENT'S BIRTHDATE ____ SOCIAL SECURITY NUMBER ____ DRIVER'S LICENSE NUMBER ____ ( ) WORK PHONE ____

IF STUDENT, NAME OF SCHOOL/COLLEGE ____ WHOM MAY WE THANK FOR REFERRING US? ____

FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____ RELATIONSHIP ____

CURRENT STREET ADDRESS ____ CITY ____ STATE ____ ZIP ____ ( ) HOME PHONE ____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

SOCIAL SECURITY NUMBER ____ ( ) WORK PHONE ____

DENTAL INSURANCE INFORMATION

INSURED PERSON'S FULL NAME ____ BIRTHDATE ____

SOCIAL SECURITY NUMBER ____ RELATIONSHIP TO PATIENT ____ ( ) WORK PHONE ____

EMPLOYER'S NAME ____ FULL ADDRESS OF EMPLOYER ____ OCCUPATION ____

INSURANCE COMPANY NAME ____ ADDRESS OF INSURANCE COMPANY ____ GROUP OR LOCAL NUMBER ____

HOW MUCH IS YOUR DEDUCTIBLE? ____ HOW MUCH HAVE YOU SATISFIED? ____ MAXIMUM ANNUAL BENEFIT? ____

DO YOU HAVE OTHER DENTAL COVERAGE? ☐ **YES** ☐ **NO** **IF YES, PLEASE COMPLETE THE FOLLOWING:** *(If a third party Insurance Policy is applicable, please notify us)*

INSURED PERSON'S FULL NAME ____ BIRTHDATE ____

SOCIAL SECURITY NUMBER ____ RELATIONSHIP TO PATIENT ____ ( ) WORK PHONE ____

EMPLOYER'S NAME ____ FULL ADDRESS OF EMPLOYER ____ OCCUPATION ____

INSURANCE COMPANY NAME ____ ADDRESS OF INSURANCE COMPANY ____ GROUP OR LOCAL NUMBER ____

HOW MUCH IS YOUR DEDUCTIBLE? ____ HOW MUCH HAVE YOU SATISFIED? ____ MAXIMUM ANNUAL BENEFIT? ____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the above patient and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or this staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY ____ RELATIONSHIP ____ DATE ____

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