PATIENT INFORMATION

PATIENT: ____
LAST NAME FIRST NAME MIDDLE

BY WHAT NAME WOULD YOU LIKE US TO ADDRESS YOU BY? _______________________

SINGLE OR MARRIED MALE OR FEMALE

ADDRESS: ____
STREET **CITY** **STATE** **ZIP**

SS#_______-_______-_______ BIRTHDATE:_____/_____/_______

HOME (______)______-______WORK:(______)______-____CELL: (______)______-_______

EMAIL ADDRESS: ________________________________

WHAT IS THE BEST WAY TO CONTACT YOU TO CONFIRM YOUR APPOINTMENTS?
PLEASE SELECT ALL THAT APPLY

O WORK O HOME O CELL OTEXT O EMAIL

YOUR OCCUPATION: __________________________EMPLOYER________________________

SPOUSE OR PARENT NAME: ____________________ EMPLOYER______________________

IN CASE OF EMERGENCY CALL? _______________PHONE#: (____)____________________

HOW WERE YOU REFERRED TO OUR OFFICE: GOOGLE, INSURANCE, LOCATION, FACEBOOK, OTHER

PATIENT REFERRAL, NAME: ____

HAVE YOU VISITED OUR WEBSITE? YES NO

INSURANCE INFORMATION

SUBSCRIBER NAME:_________________________BIRTHDATE:_____/______/______

EMPLOYER: _________________________EMPLOYEE SS#_____/_______/_______

NAME OF INSURANCE COMPANY: __________________ID#:_________________________

ASSIGNMENT & RELEASE

I am financially responsible for any service rendered. I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required to process my claim. I also authorize the dentist to release my records and x-rays requested. **A late fee will be charged without 48 hours notice for cancelled appointments.**

SIGNATURE: ____________________________DATE:_________________________________