CONFIDENTIAL PATIENT INFORMATION

Preferred Name:____________________ TODAYS DATE_____/_____/______

NAME: Last __________________________________First ____________________________Middle______________ SEX M☐ F☐

STREET ADDRESS____City___________________State______Zip________

MAILING ADDDRESS____City___________________State______Zip________

SOCIAL SECURITY #________-________-__________BIRTHDAY_______________AGE______________MARRIED? Y☐ N☐

PHONE Home Phone:(_______)______-________Work Phone:(______)_______-_________Cell Phone:(________)_______- __________

EMAIL ADDRESS____

PREFERRED METHOD OF CONTACT (Check one) ☐Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Text

Other__________

RESPONSIBLE PARTY INFORMATION

IF THE SAME AS PATIENT INFORMATION —SKIP THIS SECTION

NAME: Last__________________________________First____________________________Middle__________________ SEX M☐ F☐

ADDRESS____City_______________State______Zip_________

SOCIAL SECURITY #_________-______-_________ BIRTHDAY_________________AGE__________________ MARRIED? Y☐ N☐

EMPLOYER____OCCUPATION_____________________________________

PHONE Home Phone:(_____)________-__________Work Phone:(______)_____-________ Cell Phone:(_______)________- ___________

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME____

INSURANCE COMPANY____

INS. CO ADDRESS____

CITY__________________ST_______ZIP__________

INSURED'S EMPLOYER____

INSURED'S SSN#_____-________-________ ID#_________________________

GROUP#____

- **PLEASE GIVE A COPY OF THE CARD TO THE RECEPTIONIST**

SECONDARY DENTAL INSURANCE INFORMATION

INSURED'S NAME____

INSURANCE COMPANY____

INS. CO ADDRESS____

CITY__________________ST_______ZIP__________

INSURED'S EMPLOYER____

INSURED'S SSN#_____-___-_____ ID#_________________________

GROUP#____

- **PLEASE GIVE A COPY OF THE CARD TO THE RECEPTIONIST**

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT____________________________________RELATIONSHIP TO PATIENT____________________________________

HOME PHONE (_______)_______-_________ WORK# (______)______-_________ CELL PHONE# (____)_____-______

Consent

The undersigned hereby attest that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, and photographs. Or any other diagnostic aids deemed by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the dental office and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the dentist. Any payments received by the office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fee incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the office Notice of Privacy as required by law. I also understand that I can refuse parts of the consent by crossing out the sections that I disagree with but by doing so, the Dentist may refuse treatment.

PATIENT SIGNATURE ____DATE______/______/_______