PATIENT INFORMATION

Who referred you? _____ Social Security # _____ Date _____
Patient's Name _____ Birthdate _____
Address _____ City _____ State_____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext. ____
Email _____ Occupation _____
Employer _____ Address _____ City _____
Partent/Partner/Spouse/Guardian (please circle) _____ Birthdate _____
If different, Address _____ City _____ State_____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Ext. ____
Employer _____ Address _____ City _____
Email _____

* In case of an emergency, whom shall we notify?
Name _____ Relationship _____ Phone _____

PRIMARY
DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____
INS CO NAME _____
INS CO ADDRESS _____
CITY, STATE, ZIP _____
GROUP/POLICY # _____
SUBSCRIBER ID # _____
BIRTHDATE _____

SECONDARY
DENTAL INSURANCE INFORMAITON

EMPLOYEE NAME _____
INS CO NAME _____
INS CO ADDRESS _____
CITY, STATE, ZIP _____
GROUP/POLICY # _____
SUBSCRIBER ID # _____
BIRTHDATE _____

Patient Acknowledgements:

- I understand that all charges incurred are payable in full at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I certify that I have read (or had read to me), understand, and agree to the contents of this form.

I have read the above and agree to the same:

Signature: _____ **Date:** _____
Patient, or Guardian if a minor