



Patient information

First Name _____ Middle Initial _____ Last Name _____

By what name do you prefer us to call you? _____

Street Address _____ Mailing address (if different) _____

Town _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Email address _____ Date of Birth _____

Social Security # _____ Single Married Divorced Widowed Separated Student

Emergency Contact Name _____ Number _____

Appointment reminder preference (circle all that apply) Home Office Cell Phone Text

May we leave messages on your answering machine or voicemail? Yes No

Whom may we thank for referring you to our practice? _____

If you found us through an online search, what were you looking for? _____

Dental Benefit Information

Policy Holder _____ Relationship _____ Date of Birth _____

Is this patient currently a patient in this office? Yes No

Name of Employer _____ Employer Address _____

Insurance Company _____ Group ID# _____ Subscriber ID# _____

Insurance Company Address _____ Phone # _____

Policy Holder _____ Relationship _____ Date of Birth _____

Is this patient currently a patient in this office? Yes No

Name of Employer _____ Employer Address _____

Insurance Company _____ Group ID# _____ Subscriber ID# _____

Insurance Company Address _____ Phone # _____

- I consent to on examination by a dental provider. I understand that if treatment is recommended I will have opportunities to ask questions before accepting or refusing treatment.
I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination provided to me or my child during the period of such dental care, to their party payers and /or health practitioners.
I allow a photocopy of my signature to be used to process my insurance claims and will reaming in effect until revoked by me in writing.
I authorize and request my insurance company to pay directly to the dentist any dental benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service and I am responsible for any balance on my account.
A photocopy of this assignment is to be considered a valid as the original.

Signature _____ Date _____

Driver's License Number _____