

**PATIENT INFORMATION**

NAME \_\_\_\_\_  
LAST FIRST M PREFERRED NAME

MARRIED  SINGLE  DIVORCED  MINOR  MALE  FEMALE BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIP

TELEPHONE \_\_\_\_\_  
HOME# WORK# OTHER

PLACE OF EMPLOYMENT \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME AND LOCATION \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_  
NAME PHONE #

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME OF PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

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

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURED _____	NAME OF INSURED _____
DATE OF BIRTH _____ SS# _____	DATE OF BIRTH _____ SS# _____
INSURANCE CO. _____	INSURANCE CO. _____
INS. CO. PHONE # _____	INS. CO. PHONE # _____
GROUP # _____	GROUP # _____
EMPLOYER _____	EMPLOYER _____

**AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED**

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND HEREBY REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST (OR THE DENTAL GROUP) INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR DATE