



Thank you for selecting us for your dental healthcare! To help us meet your needs, please fill out this information form. If you have any questions or need assistance, please ask us and we'll be happy to help.

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 _____

Home Phone _(_____) _____ Work Phone _(_____) _____

Date of Birth _____ Social Security Number _____

Check appropriate box: Single Married Divorced Widowed Separated Student

(If you are a student, name of school and town _____ Full time / Part time

E-mail address _____ Cell Phone (_____) _____

Emergency Contact Name _____ Phone (_____) _____

Name of Employer (or Spouse's Employer) _____

Employer Address _____

Where may we call you for appointment confirmation? ___ Home ___ Office ___ Cell

May we leave messages on your answering machine or voice mail? ___ Yes ___ No

How did you hear about our practice? _____

Dental Insurance Information

Policy Holder _____ Relationship _____

Date of Birth _____ Social Security Number _____ Carrier ID # _____

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

Name of Employer _____

Insurance Company _____ Group ID # _____

Insurance Company Address _____

Phone Number _____

- I consent to examination by a dental provider. I understand that if treatment is recommended I will have the opportunity 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 rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.
- I allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.
- I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for any balance.
- A photocopy of this assignment is to be considered as valid as the original.

DRIVER'S LICENSE NUMBER _____ SIGNATURE _____