

Today's Date ____/____/____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex M F Date of Birth ____/____/____ Single Married Widowed DivorcedHome Address _____
Street City State ZipPhone # (____) _____ (____) _____ (____) _____
Home # Work # Mobile #

Social Security # _____ E-mail Address _____

Are you a full time student? Yes No If yes, School Name _____Employer _____
Name Address City State ZipHas any member of your family been treated in our office? Yes No If so, who? _____

How did you hear about our office? _____

Contact in case of emergency _____ (____)
Name Relationship Phone # Spouse or Parent, if minor _____ (____)
Name Address Phone #Person Responsible for Account _____
Name Relationship SS#**DENTAL INSURANCE INFORMATION**Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth ____/____/____

Subscriber's Employer _____
Name Address City State ZipWe will need to copy your insurance card or please provide us with the following information so we may verify coverage:Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs. I understand this office may photograph my face and mouth for purpose of documentation in my patient chart.

Patient, Parent or Guardian Signature _____ Date ____/____/____

I further grant my permission for this office to use my photographs for purposes of educating other patients, including placing them on our website.

Patient, Parent or Guardian Signature _____ Date ____/____/____