



Patient Name: _____
Last, First MI (Preferred Name) Date

Birth Date: _____ Gender: Male Female Married__ Single__ Other __ Child __

Phone (Home): _____ Cell Phone: _____ Social Security #: _____

Street Address: _____ City: _____ ST: _____ Zip: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Employer Name: _____ Occupation: _____

Work Phone Number: _____ Ext: _____ May we call you at work? Yes No

Who will be responsible for your account? Self: __ Spouse: __ Mother: __ Father: __ Other: __

Nearest Relative not living with you: _____ Phone: _____

Who referred you to our office?: _____

Student?: Yes No *if yes* Full time: __ Part Time: __ School Name: _____ City: _____

Spouse or Responsible Party Information

Name: _____ Relation: _____
Male Female Last, First MI

Social Security #: _____ Birth Date: _____

Street Address: _____ City: _____ ST: _____ Zip: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Phone(Home): _____ Cell Phone: _____

Employer Name: _____ Occupation: _____

Work Phone Number: _____ Ext: _____

Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insurance Co.: _____	Insurance Co.: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Name of Insured: _____	Name of Insured: _____
Phone: _____	Phone: _____
SS#: _____	SS#: _____
Employer: _____	Employer: _____
Relation to Patient: _____	Relation to Patient: _____

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim. If the office incurs expenses in trying to collect from you, such as filing a lawsuit, you agree to pay any responsible collection cost, including, but not limited to, attorney's fees we may incur.

If patient is a minor: Authorization is hereby granted to the physician to provide care for my child: _____

Signed: _____ **Date:** _____