

PATIENT  
INFORMATION

**PATIENT**  
Name \_\_\_\_\_  
*first last*  
Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Cell Phone( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_  
DL# \_\_\_\_\_  
Age \_\_\_\_\_ Birthday \_\_\_\_\_  
E-mail \_\_\_\_\_

**RESPONSIBLE PARTY**  
Name \_\_\_\_\_  
*first last*  
Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Social Security # \_\_\_\_\_  
DL# \_\_\_\_\_  
Age \_\_\_\_\_ Birthday \_\_\_\_\_  
E-mail \_\_\_\_\_

**EMPLOYMENT**  
Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone ( ) \_\_\_\_\_

**EMERGENCY CONTACT**  
Name \_\_\_\_\_  
Phone ( ) \_\_\_\_\_  
Physician \_\_\_\_\_ Phone( ) \_\_\_\_\_

**GETTING TO KNOW YOU**  
How did you hear about our office? (circle one)  
Have you seen our website?  
Family \_\_\_\_\_ Office Sign \_\_\_\_\_ Location \_\_\_\_\_  
Co-worker \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Internet \_\_\_\_\_  
Phone Book \_\_\_\_\_ Insurance Plan \_\_\_\_\_ Other \_\_\_\_\_

**INSURANCE / DENTAL PLAN**  
Plan name \_\_\_\_\_  
Address \_\_\_\_\_  
City, Zip \_\_\_\_\_  
Insurance / Plan Phone # \_\_\_\_\_  
Employer \_\_\_\_\_  
Group # \_\_\_\_\_ Plan # \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured Soc. Sec. # \_\_\_\_\_ Birthday \_\_\_\_\_

- 1 I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for charges not covered by or paid by insurance for whatever reason.
- 2 By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports, from credit reporting agencies.
- 3 I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or Claims
- 4 I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is

**X** \_\_\_\_\_  
Signature or Responsible Party or Patient Date  
(Parent if Patient is a Minor)