

**PATIENT**

Name \_\_\_\_\_  
*first last*

Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_

DL# \_\_\_\_\_

Age \_\_\_\_\_ Birthday \_\_\_\_\_

E-mail \_\_\_\_\_

**RESONSIBLE 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 \_\_\_\_\_

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.

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.

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

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 responsible for my dental treatment.

**X**

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Signature or Responsible Party or Patient  
(Parent if Patient is a Minor)

Date