PATIENT INFORMATION **DATE**

PATIENT_____ Sex: Male / Female
LAST FIRST MI

ADDRESS_____
STREET APT # CITY STATE ZIP

BIRTH DATE ____/_____/_____ **SS#**_____

TELEPHONE _____
HOME WORK CELL

Marital Status: __ single __ married __ child __ other

Employment Status: __ none __ employed __ full-time student __ part-time student
Insurance: Yes / No

Who referred you to our office? _____

Who is your general dentist? _____

SPOUSE OR "PARENT" INFORMATION

NAME_____ADDRESS_____

HOME PHONE WORK PHONE BIRTHDATE SS#

Person to contact in case of an emergency (outside of household) _____
NAME PHONE #

This office may leave messages regarding my appointments: __no
__at home answering machine __at work voice mail __with secretary __with family members

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____