PATIENT INFORMATION AND HEALTH HISTORY

Patient ______________________________________ Birthdate ________ SS# ________
Last Name First Name Middle

By what name would you like us to address you? ________________ Male or Female Single or Married

Home phone__________ Work phone __________ Cell __________ Email __________

Address ______________________________________
Street City State Zip

Your occupation ____________________ Employer ____________________

Spouse/Parents name ____________________ Employer ____________________

Who is responsible for account? (If other than yourself) ____________________

Responsible parties address ______________________________________
Street City State Zip

Home phone__________ Work phone __________ SS# __________

Responsible parties employer ______________________________________

In case of emergency call? ____________________ Day phone __________

Whom may we thank for referring you to our office? ____________________

If you have no insurance, type of payment: (circle one) Cash Check VISA-MC

INSURANCE INFORMATION

Employee name ____________________ Employee birthdate __________

Employee SS# ____________________ Employer ____________________

Name of insurance company & address ____________________ Group # __________

2ND INSURANCE (IF APPLICABLE)

Employee name ____________________ Employee birthdate __________

Employee SS# ____________________ Employer ____________________

Name of Insurance Company & Address ____________________ Group # __________

ASSIGNMENT & RELEASE

I am financially responsible for any services rendered. I hereby authorize my insurance benefits be paid directly to the dentist. I authorize the dentist to release any information required to process my claims. I also authorize the dentist to release any records and x-rays as requested. ***Cancellations must be made 48 hours in advance or a cancellation charge may apply.***

Signed ______________________________ **Today's date** __________