CONFIDENTIAL PATIENT INFORMATION - PLEASE PRINT LEGIBLY

Account No. ________-______________________
Date______________________________

I. PATIENT INFORMATION

Name:____
Sex__________ Birthdate____________ Age:_______

Address:______________________________________
____

Phone: Home (_____)___________________________

Work (_____)___________________________

Soc. Sec. No. ___________ Driver's Lic. No.__________

Employer (or School) Name
____

Employer (or School) Address
____

Marital Status________________________________
Spouse Name (If applicable)
____
Spouse Work Phone ___________________________

Please list all immediate family members:

NAME	BIRTHDATE	LAST VIST TO DENTIST

How did you find out about us? __________________
When did you last visit a dentist?________________
When were dental xrays last taken?_______________
What treatment was performed? _________________

Emergency Contact (Friend or Relative)

Name:_______________________________________
Phone Number: (___)__________________________

PARENT/RESPONSIBLE PARTY PLEASE COMPLETE
RELATIONSHIP TO PATIENT _______________

II. INSURANCE INFORMATION

COMPLETE THIS SECTION ONLY IF COVERED BY INSURANCE

Employee's Name__________________________
Social Security No.________________________
Employee Identification No.________________
Date of Hire_________ Date of Birth_________
Driver's License No.________________________

Employer (Company) Name _________________

Employer Address__________________________
____
Employer Phone Number____________________

Name of Insurance Company________________
Union/Local_____________ Group No. ________

III. DUAL INSURANCE INFORMATION

COMPLETE IF PATIENT IS COVERED BY ANY ADDITIONAL INSURANCE

Employee's Name__________________________
Social Security No.________________________
Employee Identification No.________________
Date of Hire_________ Date of Birth_________
Driver's License No.________________________

Employer (Company) Name _________________

Employer Address__________________________
____
Employer Phone Number____________________

Name of Insurance Company________________
Union/Local_____________ Group No. ________

So we may bill your insurance directly, please sign:

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the dental treatment plan and authorize dental care and release of any information relating to this claim.

X______________________________ (Signature of Insured)

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the dental treatment plan and authorize dental care and release of any information relating to this claim.

X______________________________ (Signature of Insured)

FOR SIX MONTH RECALL ONLY

I hereby confirm there have been no changes to the above information.

X______________________________ (Signature of Insured) Date________________