

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Social Sec. # _____
First Name Middle Initial Last Name

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Email address _____ Do you prefer email over phone? Yes No

Name of school if full-time student: _____

How did you find out about our office? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Primary Insurance

Person Responsible for Account _____
First Name Middle Initial Last Name

Relation to Patient _____ Birthdate _____ Social Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

AUTHORIZATION

My signature below authorizes the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist my insurance benefits that would otherwise be payable to me (unless I have Delta Dental). I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

FAILED APPOINTMENT POLICY: I understand that I may be charged \$40 per hour for a broken appointment if 24 hours notice is not given to ensure that another patient may use the appointment time.

Signature _____ Date _____