F___/ M___

FULL NAME OF PATIENT | BIRTHDATE | SOCIAL SECURITY NUMBER

RESIDENCE ADDRESS | STREET | CITY | STATE | ZIP CODE

TELEPHONE | HOME | WORK | CELL | E-MAIL

WHO MAY WE THANK FOR YOUR REFERRAL?____________________

OCCUPATION | EMPLOYER

ADDRESS OF EMPLOYER | STREET | CITY | ZIP CODE

FULL NAME OF SPOUSE, PARENT OR GUARDIAN | TELEPHONE

EMERGENCY CONTACT, OTHER THAN THAT ABOVE | TELEPHONE

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

I WILL BE PAYING CASH_____ CHECK_____ CREDIT CARD_____

DENTAL INSURANCE INFORMATION

FIRST

Name of Employee: ____________________

Social Security #: ____________________

Relationship to Patient: ____________________

Employee Birthdate: ____________________

Name of Insurance: ____________________

Address of Insurance: ____________________

____

Group Number: ____________________

Employer: ____________________

SECOND

Name of Employee: ____________________

Social Security #: ____________________

Relationship to Patient: ____________________

Employee Birthdate: ____________________

Name of Insurance: ____________________

Address of Insurance: ____________________

____

Group Number: ____________________

Employer: ____________________

Acknowledgement & Authority

I consent to treatment as necessary or desirable for the care of the above named patient. I also acknowledge full responsibililty for the payment of such services and agree to pay for them, in full, at the TIME OF SERVICE, unless other arrangements are made with the Financial Department. I authorize this office to make credit inquiries on my name for the purpose of obtaining credit. In the event of delinquency I agree to pay cost of collection and reasonable attorney's fees.

* DATE____________ SIGNED______________________________

PATIENT INFORMATION