



Patient Information

(Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

If Student, Name of School/College _____ City _____ State/Prov. _____ Zip/P.C. _____

How You Found Us? <input type="checkbox"/> Google Search <input type="checkbox"/> Email from us <input type="checkbox"/> Post Card <input type="checkbox"/> Patient Referral (Name: _____)
<input type="checkbox"/> One of our Staff <input type="checkbox"/> Our Sign <input type="checkbox"/> Insurance <input type="checkbox"/> Other _____

Person to Contact in Case of Emergency _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Additional Dental Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group# _____ Policy ID/# _____

Do You Have Medical Insurance? Yes No

Pharmacy Name _____ Pharmacy Phone _____

Payment In Full at Each Appointment. <input type="checkbox"/> Cash <input type="checkbox"/> Personal Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Debit Card
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Responsible Party

Person Financially Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? Yes No

Authorization and Release

Payment is due in full at time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. 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 release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that i may need during diagnosis and treatment, with my informed consent.

X _____
 Signature of Patient, Parent, Guardian or Personal Representative Date Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient