~WELCOME~

Patient Information (Confidential) Date_____
Name_____Date of birth_____
Address_____City_____State____Zip_____
Social Security #_____Home phone_____Cell phone_____
Patient's or parent's place of employment_____Work phone_____
Please check one: ___Single___Married___Divorced___Separated___Widowed___Minor
Spouse or parent's name_____
Whom may we thank for referring you?_____
Emergency contact_____Relationship_____Phone_____
Authorization, release and agreement to pay for services rendered
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practioners.
I authorize and hearby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
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 on behalf of my dependents.

X_____Date_____
Signature of patient (or parent/guardian if patient is a minor)