

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  MARRIED  SINGLE  MALE  FEMALE

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

BIRTHDATE: \_\_\_\_\_ PHONE #: \_\_\_\_\_ SS# \_\_\_\_\_

EMAIL: \_\_\_\_\_ WHO MAY WE THANK FOR YOUR REFERRAL: \_\_\_\_\_

DENTAL INSURANCE INFO: \_\_\_\_\_

**SEASONAL ADDRESS & DATES OUT OF THIS AREA**

STREET \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

DATES OUT OF AREA \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY (Outside of immediate Family/Household)**

NAME \_\_\_\_\_

STREET \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE STATE DRIVER'S LICENSE #

**SPOUSE INFORMATION**

NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_

DENTAL INSURANCE INFO \_\_\_\_\_

**METHOD OF PAYMENT**

PAYMENT IN FULL IS DUE AT EACH APPOINTMENT.  
WE ACCEPT CASH/PERSONAL CHECK/VISA/MASTER CARD/  
AMERICAN EXPRESS/DISCOVER

**DENTAL INSURANCE**

I understand that my dental insurance is a contract between me and the insurance carrier, and that I am still responsible for all dental fees. I understand that I will be charged for all dental treatment. Any payments received by the Dental Office from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

\_\_\_\_\_  
SIGNATURE