



Thank you for selecting our dental healthcare team! The benefits of a happy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can serve you.

PATIENT INFORMATION (CONFIDENTIAL)

Patient Name _____ DOB _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
DL # _____ Email _____ Sex: ___M___F Marital Status: ___S___M___D___O
Employer _____ If student, name of school _____ FT ___ PT ___
How did you hear about us? Brochure ___ Insurance ___ Patient (name) _____ Other _____
Person to contact in case of emergency: _____ Phone (____) _____

DENTAL INSURANCE INFORMATION

Insurance Company _____ Phone (____) _____
Subscriber's name _____ DOB _____ SS# _____
Insurance ID# _____ Relationship to patient _____ Employer _____
Subscriber's address _____ City _____ State _____ Zip _____

ASSIGNMENT AND RELEASE

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 confidence and it is my responsibility to inform the office of any changes in my personal information or medical status. I authorize the release of my information to all my insurance companies and for my doctor to act as my agent in helping me obtain payment from my insurance company. I authorize payment directly to my doctor. **I understand that I am responsible for my bill.**

SIGNATURE (patient or legal guardian): _____ Date _____

Parent/Guardian accompanying minor _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
SS# _____ DL # _____