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Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: ___ / ___ / ___ Age: ___ Social Security#: _____

Sex: Male Female Check One: Child Single Married Divorced Widow

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

Occupation: _____ E-mail Address: _____

Who may we thank for referring you: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Responsible Party

Same as above

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: ___ / ___ / ___ Age: ___ Social Security#: _____

Sex: Male Female Relationship to patient: Self Spouse Parent Other

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

Occupation: _____ E-mail Address: _____

Primary Dental Insurance Information

N/A

Name of Policy Holder: _____ Date of Birth: ____/____/____

Insured Social Security #: _____ Relationship to patient: Self Spouse Parent Other

Insurance Company Name: _____

Member ID: _____ Group Number: _____

Employer Name: _____ Phone: _____

Secondary Dental Insurance Information

N/A

Name of Policy Holder: _____ Date of Birth: ____/____/____

Insured Social Security #: _____ Relationship to patient: Self Spouse Parent Other

Insurance Company Name: _____

Member ID: _____ Group Number: _____

Employer Name: _____ Phone: _____

Consent for Treatment

1. I hereby authorize the dentist or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature: _____ Relationship to Patient: _____

Date: _____