Thank you for taking the time to complete these forms.

PATIENT'S NAME: FIRST	LAST	MIDDLE	PREFERRED NAME (OPTIONAL)
BIRTHDATE (mm/dd/yyyy)	GENDER ◯ MALE ◯ FEMALE	HOME ADDRESS (Number, Street, Route, Etc.)	

CITY	STATE	ZIP	HOME PHONE (XXX-XXX-XXXX)	CELL PHONE (XXX-XXX-XXXX)	OTHER PHONE (XXX-XXX-XXXX)

EMAIL ADDRESS (EXAMPLE@DOMAIN.COM):

MARTIAL STATUS OF PARENTS (Check one) ◯ MARRIED ◯ SINGLE ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED ◯ PARTNER

WITH WHOM DOES PATIENT LIVE?	WHO DO WE CONTACT TO SCHEDULE AND INFORM?

Please provide the following information if the patient is under 18 years of age or has a legal guardian

Person responsible for payment of services?:

Relationship to patient:

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
MAILING ADDRESS (if different from patient)	CITY	STATE	ZIP
Employer	Present Position	Work # is it OK to call your work? ◯ Yes ◯ No	

Other Parent/Guardian

Relationship to patient:

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
MAILING ADDRESS (if different from patient)	CITY	STATE	ZIP
Employer	Present Position	Work # is it OK to call your work? ◯ Yes ◯ No	

Primary Dental Insurance:

POLICY HOLDER: FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
Employer:	Group Number	Insurance Company	
Dental Insurance Address (Primary)	CITY	STATE	ZIP
INSURANCE PHONE NUMBER (XXX-XXX-XXXX)			

Secondary Dental Insurance:

POLICY HOLDER: FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (mm/dd/yyyy)
Employer:	Group Number	Insurance Company	
Dental Insurance Address (Primary)	CITY	STATE	ZIP
INSURANCE PHONE NUMBER (XXX-XXX-XXXX)			

Who can we thank for referring you to our practice?	Name

EMERGENCY CONTACT: FIRST NAME	LAST	PHONE NUMBER	RELATIONSHIP TO PATIENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill or services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature:	Date: