Today's Date: _____

Patient's Name: _____ Gender: _____

Patient Date of Birth: _____

If Child, Parent's Name: _____

How you wish to be addressed: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Employer: _____

Position: _____

Spouse Name: _____

Spouse Employer: _____

Position: _____

Who is responsible for this account? _____

Purpose of first visit: _____

Other Family Members in this practice: _____

Whom may we thank for this referral: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

CONSENT: I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my records shall be effective until I revoke it in writing. I attest to the accuracy of the information on this page.

Patient or Guardian Signature: _____ **Date:** _____

Our practice is not affiliated with any dental or medical insurance plans as a preferred provider. As a result, we ask for payment at the time services are rendered. We will be happy to assist by providing our patients with information to furnish their insurance companies for potential reimbursement.

Medical Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____

Dental Insurance

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Phone Number: _____

Policy #: _____

Group # : _____