Get acquainted information

Patient Information

Name: Mr.Mrs.Ms.Dr. _____Date_____

Preferred/Nick- name_____Male_____Female_____

Street Address_____

City_____State_____Zip code_____

Phone # (home)_____(work)_____(cell)_____

Birth Date_____Social Security #_____

Whom may we contact in case of emergency?

Name_____Phone_____

Whom may we thank for referring you?_____

Do you have Dental Insurance YES_____NO_____

Primary Insurance and/or Person Responsible for Payment

Name _____

Birth Date_____SS#_____

Employer Name_____Hourly or Salary

Insurance Co_____Phone #_____

Group #_____Contract #_____

Secondary Insurance and/or spouse

Name_____Birth Date_____SS#_____
Employer Name_____Insurance Co_____

I authorize the dentist and dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

X_____
Patient Signature Date

INSURANCE COVERAGE IS ONLY AN ESTIMATE ___ PATIENT OR GUARANTOR IS RESPONSABLE FOR ALL TREATMENT NOT COVERED BY INSURANCE.

Patient or Guarantor's Signature: X_____Date_____