

**PATIENT INFORMATION**

(PLEASE PRINT)

**CONFIDENTIAL**

DATE \_\_\_\_\_

NAME: \_\_\_\_\_  
LAST FIRST MI PREFERRED: \_\_\_\_\_  
(NICKNAME)SEX:  Male  FemaleMARITAL STATUS:  Partnered  Single  Minor  OtherBIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SOC. SECURITY #: \_\_\_\_\_  
Month Day Year

HOME ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_ OTHER \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_  
(Name) (Phone)

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**RESPONSIBLE PARTY (If not patient)**NAME OF PERSON RELATIONSHIP  
RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_ TO PATIENT: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**CONSENT:**

1. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
2. I authorize release of any information concerning my or my dependant's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
3. I authorize release of any information concerning my or my dependant's health care and treatment to another dentist.
4. I understand that responsibility for payment of dental service for my dependants or myself is mine, due and payable at the time of service unless other arrangements have been made prior to treatment. In the event payment is not received by the agreed upon date and outside collection action is taken, additional collection or attorney charges/fees may be added to my account. I understand where appropriate, credit bureau reports may be obtained. We will charge a fee of \$25.00 for returned checks.
5. I understand that 24 hrs notice is required to cancel or reschedule appointments or I will be charged \$150.00 p/hr of scheduled appointment time.
6. I understand that it is my responsibility to advise your office of any changes to this form or in my medical history.
7. I attest to the accuracy of the information on this page.

SIGNATURE OF PATIENT OR GUARDIAN: \_\_\_\_\_