

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_

### In Case of Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Whom can we thank for referring you to us? \_\_\_\_\_

### Account Information

Person responsible for this account is the same as above

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Additional Insurance

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_