PATIENT INFORMATION

Patient Name Birth Date

Who referred you to this office? Social Security #

Address _____ City _____ ST____ ZIP _____

___Male ___Female ___Single ___Married ___Child ___Other

Home Phone Work Phone Ext

Cell Phone Pager E-Mail

Employer City Occupation

Name of Spouse / Partner / Parent / Guardian Birth Date
(circle one)
Social Security #

Address if different City ST ZIP

Home Phone Work Phone Ext

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name Relationship Phone

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
EMPLOYEE NAME	EMPLOYEE NAME
INS CO NAME	INS CO NAME
INS CO ADDRESS	INS CO ADDRESS
INS CO CITY, ST, ZIP	INS CO CITY, ST, ZIP
INSURANCE PHONE	INSURANCE PHONE
GROUP / POLICY #	GROUP / POLICY #
EMPLOYEE SS #	EMPLOYEE SS #

Patient Acknowledgments:

- I understand that I am responsible for all fees incurred at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic, educational, marketing and advertising purposes. By signing this, I wave any claims of breach of privacy pertaining to the release of the above mentioned photographic or digital images.
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.
- I have read the above:

_____ _____
Signature of Parent or Guardian if a minor Date