TODAYS DATE:_____

Patient's Name_____ Preferred Name_____ SS #_____

Who referred you to this office?_____ Birthdate _____Sex __M___F__

Have we seen any member of your family?_____

Patient Address _____#____ City _____ ST____ ZIP _____

Home Phone _____ Cell Phone_____ Work Phone _____Ext _____

Email address_____

Employer _____City _____ Occupation _____

Name of Spouse / Parent _____ Birthdate _____SS#_____
(circle one)

Address (if different) _____ City _____ ST ___ ZIP _____

Home Phone _____ Cell Phone_____ Work Phone _____Ext_____

Employer _____City _____ Occupation _____

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

Name _____Relationship _____Phone _____

PRIMARY DENTAL INSURANCE

EMPLOYEE NAME _____

EMPLOYER_____

INS C0 NAME_____

GROUP / POLICY # _____

EMPLOYEE ID/SS # _____

BIRTHDATE _____

SECONDARY DENTAL INSURANCE

EMPLOYEE NAME _____

EMPLOYER_____

INS C0 NAME _____

GROUP / POLICY # _____

EMPLOYEE ID/SS _____

BIRTHDATE _____

ASSIGNMENT and RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. This office reserves the right to charge for failed appointments or appointments cancelled within 24 hours.

I consent to the taking of photographs and x-rays before, during, and after treatment.

I certify that I have read or had read to me, the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

PATIENT INFORMATION QUESTIONNAIRE