PATIENT INFORMATION

NAME______________________________________BIRTHDATE___________________S.S. NO.________________

ADDRESS__________________________________CITY_________________ZIP_________PHONE___________

EMPLOYED BY____OCCUPATION______________________________

BUSINESS ADDRESS____________________________________PHONE______________________EXT._______

HOW WOULD LIKE TO CONTACTED; TEXT, EMAIL OR PHONE. PLEASE PROVIDE___________________________

SPOUSE OR PARENT'S NAME____________________________________BIRTHDATE________________________

S.S. NO.______________PHONE__________________ADDRESS____

CITY________________ZIP____________EMPLOYED BY____

BUSINESS ADDRESS____PHONE_________________EXT._______

DENTAL INSURANCE?______NAME OF INSURANCE__________________________POLICY NUMBER__________

ADDRESS OF INSURANCE____GROUP NUMBER________

POLICY HOLDER'S NAME____S.S. NO.______________________

SECONDARY INSURANCE?____NAME OF INSURANCE____

ADDRESS OF INSURANCE__________________________________POLICY NUMBER________________________

POLICY HOLDER'S NAME____S.S. NO.______________________

WHO MAY WE CONTACT IN CASE OF AN EMERGENCY? NAME____

ADDRESS_____________________________CITY____________________ZIP___________PHONE____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_______________________________________

I HEREBY AUTHORIZE payment directly to the doctor of benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization. I also authorize the release of any medical information relating to this claim, and if my account should become delinquent of more than 90 days an interest fee of 1% per month will incur to my account.

SIGNATURE OF PATIENT OR INSURED____