WELCOME

DATE:_______________

NAME:____PREFER TO BE CALLED:________________________________

BIRTHDATE:________________________AGE:__________SOCIAL SECURITY NUMBER (required)_______________________

ADDRESS:____

MALE_____ FEMALE_____ MINOR____ SINGLE____ MARRIED____ DIVORCED____ WIDOWED____

TELEPHONE NUMBERS:

HOME:_________________________________WORK:_______________________EXT________CELL:______________________

HOW DID YOU HEAR ABOUT OUR OFFICE?____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

NAME:____RELATION:_____________________________________

PHONE NUMBERS: HOME:_________________________CELL:___________________WORK:___________________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:____PHONE #___________________________

ADDRESS:____GROUP#__________________________

INSURED'S NAME:____BIRTHDATE:_____________ID#______________________

EMPLOYER:____RELATION:_______________________________

IF YOU HAVE SECONDARY COVERAGE PLEASE LET THE FRONT OFFICE STAFF KNOW

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

NAME:____RELATION:______________________________

SOCIAL SECURITY NUMBER (required)_____________________BIRHTDATE:_____________DRIVERS LICENSE#__________

BILLING ADDRESS:____

AUTHORIZATION TO RELEASE

I authorize the dentist and any associate or team member to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered on my behalf or my dependents at which time I will pay that in addition to my estimated portion due at time of procedure.

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(SIGNATURE) **(DATE)**