PATIENT INFORMATION

NAME:_____

MARRIED SINGLE MINOR MALE FEMALE

MAILING ADDRESS:_____ _____**CITY**:_____**STATE:**_____**ZIP**_____

BIRTHDATE:_____ _____ **SS#**_____

STATE DRIVERS LICENSE #_____

HOME PHONE:_____ **EMAIL ADDRESS:**_____

CELL PHONE:_____ _____**WORK PHONE:**_____

PLACE OF EMPLOYMENT(OR SCHOOL):_____

DENTAL INSURANCE:_____

PERSON RESPONSIBLE FOR ACCOUNT: PATIENT FATHER(HUSBAND) MOTHER(WIFE) GUARDIAN

PERSON TO CONTACT IN CASE OF EMERGENCY OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD

NAME:_____

ADDRESS:_____

TELEPHONE:_____

AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFTIS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE THE DENTAL OFFICE TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. THE INFORMATION ON THIS PAGE AND THE MEDICAL HISTORY ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF RESPONSIBLE PARTY:_____

DATE:_____