Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____Middle: _____ Last: _____Jr/Sr:____

Address: **(Mailing):**_____ City: _____ State:_____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ May we text you? (circle) **Yes No**

Email Address: _____ May we contact you by email? (circle) **Yes No**

Patient Social Security Number:_____ Patient Date of Birth: _____Gender: (circle) **M F**

Emergency Contact:_____ Phone: _____

Preferred Pharmacy_____

How did you hear about us?

☐ Newspaper ☐ Radio ☐ Internet ☐ Referral, whom may we thank: _____ ☐ Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber ID/SSN		Subscriber ID/SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

Authorization for Release of Dental Records to External Parties

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ All treatment information

Signature of Patient (or Patient Representative) _____ Date: _____

Printed Name of Patient (or Patient Representative) _____