Welcome

PATIENT INFORMATION

NAME: _____ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT. # CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: ❑ _____ ❑ _____
MO DAY YR HOME OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE: _____ S.S.# _____

DENTAL INSURANCE CO.: _____ GROUP NO: _____

WHO REFERRED YOU TO THE OFFICE: _____

FAMILY INFORMATION

FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name: _____ (LAST FIRST M)	Name: _____ (LAST FIRST M)
Address: _____ (STREET APT. # CITY STATE ZIP)	Address: _____ (STREET APT. # CITY STATE ZIP)
Telephone #: _____ (HOME WORK)	Telephone #: _____ (HOME WORK)
DOB/SS#: _____ (MO DAY YR SS #)	DOB/SS#: _____ (MO DAY YR SS #)
Employer: _____	Employer: _____
Dental Insurance Co.: _____ (GROUP #)	Dental Insurance Co. _____ (GROUP #)

EMERGENCY CONTACT

Name.: _____ TELEPHONE NO: _____
LAST FIRST M

ADDRESS: _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

PLEASE CHECK ONE OF THE FOLLOWING:

❑ Check or cash at each appointment

❑ Mastercard or VISA at each appointment

❑ Monthly budget payments (please request CareCredit application)

AUTHORIZATION

I hereby authorize the Dental Office to process a credit report to open an account for billing purposes. For insurance processing, I authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

SIGNATURE OF RESPONSIBLE PARTY