



Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
If child, Parent's Name: \_\_\_\_\_

**CONTACT INFORMATION**

Residence Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_

**HOME ADDRESS**

Street: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_

**BUSINESS INFORMATION**

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_  
Present Position: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_  
Person Responsible for Account: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Residence Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REFERRAL INFORMATION**

Purpose of Visit: \_\_\_\_\_  
Other Family Members Cared for by Practice:  
\_\_\_\_\_  
How did you hear about this practice?  
\_\_\_\_\_  
Name of referral:  
\_\_\_\_\_

**DENTAL INSURANCE**

**First Coverage**

Employee Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer Name: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_  
Insurer Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Program/Policy #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Union Local/Group: \_\_\_\_\_

**Second Coverage**

Employee Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer Name: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_  
Insurer Address: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Program/Policy #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Union Local/Group: \_\_\_\_\_

**Consent**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment and payments.

My consent to disclosure of records shall be effective until I revoke it in writing. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I attest to the accuracy of the information on this page.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date Signed)