HOWARD SILVER, DDS

PINNACLE FAMILY DENTAL
ADVANCING DENTISTRY TO NEW HEIGHTS

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)

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www.HowardSilverDDS.com