

Name \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) |  M  F |  S  M  W  D  
Sex Marital Status

Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip Code)

Home Phone ( ) - Cell Phone ( ) - Email \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone ( ) - ext. Date of Birth \_\_\_\_\_

Patient SS# \_\_\_\_\_ Spouse Name \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder _____	Policy Holder _____
Date of Birth _____	Date of Birth _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Group # _____	Group # _____
SS# _____ ID# _____	SS# _____ ID# _____
Name of Insurance Co. _____	Name of Insurance Co. _____
Claims Address _____	Claims Address _____
Phone # ( ) - _____	Phone # ( ) - _____

Hobbies and Interests \_\_\_\_\_

Referred to our office by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # ( ) - \_\_\_\_\_

I hereby 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. 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 and dental histories are correct to the best of my knowledge.

\_\_\_\_\_  
 (Signature of Dentist)

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