Welcome to our office. We are complimented that you have selected us to provide dental care for you and your family. So that we can serve you better, please complete both sides of this patient history form.

PATIENT INFORMATION

Today's Date_____ Cell Number_____ E-mail_____

Patient's Name_____

Address _____ City_____ State_____ Zip_____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY/BILLING INFORMATION

Name _____

Address _____ City _____ State_____ Zip_____

Mailing Address (If different than above) _____

How long at this address _____ Home Phone_____ Work Phone_____ Ext._____

Previous Address (if less than 3 years) _____ How long at this address?_____

Social Security # _____ Birthdate_____ Relationship to Patient _____

Employer, if self, list name of business _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Occupation_____ No. Years Employed_____ Work Phone_____

INSURANCE INFORMATION

Insured's Name _____ Birthdate_____ Insured's Soc. Sec. #_____

Insurance Company _____ Group No. _____ Local No._____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Birthdate_____ Insured's Soc. Sec. #_____

Insurance Co._____ Group No._____ Local No._____

Insurance Co. Address _____

Insured's Employer _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with my treatment, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a monthly billing charge will be added to any balance above 90 days. I agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. If it becomes necessary to effect collections of amount, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits. A 5% courtesy is extended to patients who pay by cash or check on date of service.

ABOVE INFORMATION IS TRUE

Patient Signature _____ Date_____ / _____ / _____

parent sign for minor