

Patient Information

Chart# (Office use only)

 Mr.  Mrs.  Ms.  Dr.

Patient's Full Name Preferred Name

 Male  Female  Single  Married  Divorced  Widowed  Child Social Security # Birth Date

Home Address City/St/Zip

Home Phone Work Ext. Cell E-mail Address

Who May We Thank For Referring You To Us?

Parent/Guardian Consent

I hereby give consent for treatment of my child, , I understand the proposed treatment plan

may include, when deemed necessary, the use of local anesthetic for the comfort and well being of the child. I understand that the recommendation made to me may change during the treatment.

Signature of Parent/Guardian Date

Spouse or Parent/Guardian Information

 Mr.  Mrs.  Ms.  Dr.

Name Nickname

 Male  Female  Single  Married  Divorced  Widowed  Child Social Security # Birth Date

Home Address City/St/Zip

Home Phone Work Ext. Cell E-mail Address

Dental Insurance Information

Insured’s Name Relationship To Patient Social Security #

Work Address Insurance Company

Insurance Company Address

Birth Date  Self  Employer City/St/Zip

Spouse  Child  Other

Group#

Phone#

Subscriber ID# Other Contact Information

Closest Relative Not Living With You Address

City/St/Zip Phone #

After you fill out this information please print this PDF and bring it to the office for your appointment.