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 | Birth Date

Relationship To Patient | ◯ Self ◯ Spouse ◯ Child ◯ Other

Social Security # | Employer

Work Address | City/St/Zip

Insurance Company | Group#

Insurance Company Address

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.