Please complete the following confidential information for your appointment.

Last Name: ______________________ First Name: ________________ Prefers to be called: _______________

Address: _________________________________ City: _________________ State: ________ Zip: _________

Phone: Home:______________________ Work:_____________________ Cell: _______________________

E-Mail: ____ Marital Status: ________________________

Date of Birth: ______________________ Sex: _________ Social Security No.:_________________________

Whom can we thank for referring you? ____

Employer:____ Occupation:______________________________

Employer Address:________________________________ City:________________ State:_____ Zip:_______

Person to contact in case of emergency:________________________________ Relationship:______________

Emergency Contact Phone Number: Home:_________________________ Cell:_________________________

Dental Insurance:

Insured's Name:_________________________________ Relationship to Patient:________________________

Date of Birth:___________ Insured's Social Security No.:_______________ Insured's I.D. No.:______________

Insurance Company Name:_____________________________ Insurance Phone Number:_________________

Insurance Company Group Number:__________________ Employer:________________________________

Insurance Address:___________________________ City:__________________ State:_______ Zip:________

Secondary Dental Insurance:

Insured's Name:_________________________________ Relationship to Patient:________________________

Date of Birth:___________ Insured's Social Security No.:_______________ Insured's I.D. No.:______________

Insurance Company Name:_____________________________ Insurance Phone Number:_________________

Insurance Company Group Number:__________________ Employer:________________________________

Insurance Address:___________________________ City:__________________ State:_______ Zip:________

Consent:

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

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 needs. I authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made prior to treatment.

Patient Signature:____ Date:_________________

Print Name:____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR INSURANCE CARRIER, MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.