To help us meet all your dental needs, please fill out this form completely in ink.
If you have questions or need assistance, please ask and we will be happy to help.

Date: ________ / _________ / _________

Personal Information

Name: Last ____ First _______________________________ (Preferred) _________________________

Date of Birth ______________________________ SSN ___________________________________ Gender: Male Female (please circle)

Home Address ____ City ________________________ State _____________ Zip ______________

Cell Phone _____________________________ Work Phone _____________________________ Home Phone _____________________________

Email ____ Employer ____

Person to Contact in an Emergency ____ Phone _______________________________

Whom may we thank for referring you? ____

Responsible Party Information

Name: Last ___________________________________ First ___________________________ Relationship to Patient _________________________________

Address ____ Phone ____________________________ DOB ________________________

Driver's License # _______________________________ SSN ___________________________ Employer ___________________________________

Dental Insurance Information

Name of Policy Holder ____ Policy Holder's Birthdate ___________________________

Policy Holder SSN ____________________________________ Policy Holder Employer ____

Dental Insurance ______________________ Phone # ___________________ Group # ___________________ Policy/ ID # _____________________

Authorization Information

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of photographs and images for demonstrative and educational purposes.

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Patient Signature (Or parent signature if the patient is a minor)

Date ________ / ________ / ________