

PATIENT DENTAL RECORD

PATIENT No: _____ ACCOUNT No: _____ TYPE _____

WE have the interest and desire to listen, really listen, to what you are saying. Please don't hesitate to ask about anything you don't understand. You are dealing with members of a team whose *primary job* is to serve you... WE promise that you will never leave feeling that no one cares.

In order to begin treatment, the following information is necessary. Please complete *fully* and *print* legibly. All information, of course, will be held in strict confidence.

PATIENT HISTORY INFORMATION

PLEASE
PRINT

PATIENT'S NAME _____ HOME PHONE _____
 SOC. SEC. No. _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PATIENT'S EMPLOYER _____ WORK PHONE _____
 SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____
 PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____
 STUDENT: FULL TIME PART TIME SCHOOL _____ CITY _____
 IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT YES NO IF YES WHEN? _____

RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST FIRST MIDDLE
 RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____
 MAILING ADDRESS _____ CITY _____ ZIP _____
 SOC. SEC. No. _____ DRIVER'S LICENSE No. _____
 EMPLOYER _____ OCCUPATION _____
 EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____
 HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? YES NO
 NAME _____ WHEN? _____
 DENTAL INSURANCE YES NO SECONDARY INSURANCE YES NO
 INSURED'S NAME _____ INSURED'S NAME _____
 SS# _____ BIRTHDATE _____ SS# _____ BIRTHDATE _____
 EMPLOYER _____ EMPLOYER _____
 INS. CO. or PLAN _____ INS. CO. or PLAN _____
 UNION/GRP. NAME _____ UNION/GRP. NAME _____
 GRP. or POLICY # _____ LOCAL # _____ GRP. or POLICY # _____ LOCAL # _____
 DATE EMPLOYED _____ DATE EMPLOYED _____
 HOW DID YOU HEAR ABOUT THIS OFFICE? FORMER PATIENT (WHO? _____)
 UNION TELEPHONE BOOK SAW BLDG./SIGN EMPLOYER
 ADVERTISEMENT (WHICH? _____)
 OTHER _____
 WHY ARE YOU HERE TODAY? _____
CHECK UP, TOOTHACHE, CONSULTATION, ETC.

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me.

PATIENT _____

DATE _____

RESPONSIBLE PARTY _____

DATE _____