Patient Information

Date

Welcome to our office. We appreciate the confidence you place with us to provide your dental services. To assist us in serving you, please complete this form (front and back). The information collected on this form is completely confidential and necessary to provide you with dental care in a safe and efficient manner. As long as you are a patient with us, we will do our best to keep your personal and medical information up-to-date. Please help by keeping us informed of any changes, and if you have any questions, at any time, please don't hesitate to ask.

Patient Name		Date of Birth	
Home Address	City	State	Zip
Mailing Address (if different)	City	State	Zip
Primary Telephone	Alternate Telephone		
Email Address	Can we leave a message on your Primary and Alternate Telephone? Please circle:	Yes	No
Spouse's Name / Parent's or Guardian's Name (if Patient is child)	Phone Number		
Spouse's/Parent's/Guardian's Address (if different)	City	State	Zip

Dental Insurance

Primary Insurance		Secondary Insurance	
Group Number		Group Number	
Employee (if not patient)	Date of Birth	Employee (if not patient)	Date of Birth
Employer		Employer	
Insurance ID #		Insurance ID #	

Emergency Contact Information

Person to Contact in Case of Emergency		Phone Number	
Address	City	State	Zip
Closest Relative Not Living With You		Phone Number	
Address	City	State	Zip

Other Information

Who referred you to our office?	Is another member of your family a patient at our office?
If not referred, how did you find our office?	

Consent for Treatment

1. **I authorize the doctor or designated staff to take x-rays, study models, or other diagnostic aids necessary to make a thorough diagnosis of my dental needs.**
2. **I agree that, based on this diagnosis, a recommended treatment plan will be developed and mutually agreed upon before treatment begins.**
3. **I understand that anesthetics, sedatives, and/or other medications may be used as necessary for your comfort and safety, with the understanding that such medications embody certain risks. I may ask for a recital of any possible complications.**
4. **I agree that payment for all services rendered to me or my dependents is my responsibility and due at the time of service unless other arrangements have been made.**

Patient / Guardian signature	Date