



OFFICE
USE ONLY

Chart# _____

Date ____/____/____

**PLEASE PRINT
PATIENT INFORMATION**

Last Name _____ First _____ Middle _____

How would you like to be addressed? _____ Home Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

How Long _____

Sex M F	Date of Birth Mo. Day Yr.	Marital Status S M W D	Social Security																	
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Driver's License # _____ State _____ Occupation _____ If student, FT /PT? Circle one

Employer's Name _____ Business Phone _____

Employer's Address _____

PARTY RESPONSIBLE IF OTHER THAN PATIENT

Last Name _____ First _____ Middle _____

How would you like to be addressed? _____ Home Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

How Long _____ Relationship To Patient _____

Sex M F	Date of Birth Mo. Day Yr.	Marital Status S M W D	Social Security																	
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Driver's License # _____ State _____ Occupation _____ If student, FT /PT? Circle one

Employer's Name _____ Business Phone _____

Employer's Address _____

DENTAL INSURANCE YES / NO IF YES FILL OUT THE INFORMATION BELOW

Insured Party _____	Policy # _____	Social Security # _____
Employer _____	Phone # _____	Insurance Company _____
Send Claims To _____	Phone # _____	
I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE.		I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST ON THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
Signed (Patient, or Parent if Minor) _____	Date _____	Signed (Insured Person) _____
		Date _____

Previous Dentist's Name _____ Physician's Name _____

Name & Address of Nearest Living Relative _____

Is any other member of your family a patient here? Yes No If so, patient's name _____

Whom may we contact in case of emergency? _____ Phone # _____

How did you find out about our office? (Please circle one)

- 1. Referred by a patient. Who? _____
- 2. Referred by one of our employees, Who? _____
- 3. Yellow pages
- 4. Newspapers
- 5. Radio
- 6. TV
- 7. Direct Mail
- 8. Brochure
- 9. Your employer
- 10. Other

PATIENT INFORMATION