PATIENT INFORMATION

(THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL)

TODAY'S DATE _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____

( ) HOME PHONE _____ ( ) CELL PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLACE OF EMPLOYMENT _____ EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

OCCUPATION _____

PATIENT'S BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ TEXAS DRIVER'S LICENSE NUMBER _____ ( ) WORK PHONE _____ EXT. _____

IF A STUDENT, NAME OF SCHOOL/COLLEGE _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

FINANCIAL INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

( ) HOME PHONE _____ ( ) CELL PHONE _____ ( ) WORK PHONE _____

PLACE OF EMPLOYMENT _____ EMPLOYERS ADDRESS _____ CITY _____ ZIP _____

RESPONSIBLE PARTY EMAIL _____ SOCIAL SECURITY NUMBER _____

DENTAL INSURANCE INFORMATION

INSURED PERSON'S FULL NAME _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ ( ) WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP ID NUMBER _____ UNION OR LOCAL NAME _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

DO YOU HAVE OTHER DENTAL COVERAGE? _____ YES _____ NO (IF YES, COMPLETE THE FOLLOWING)

INSURED PERSON'S FULL NAME _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ ( ) WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP ID NUMBER _____ UNION OR LOCAL NAME _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

FOR YOUR INFORMATION

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he/she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his/her staff.

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

PLEASE COMPLETE REVERSE SIDE