

PATIENT INFORMATION

DATE: _____

NAME: _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT.# CITY STATE ZIP

BIRTHDATE: _____ TELEPHONE: _____
MONTH DAY YEAR HOME WORK
ARE CALLS TO YOUR WORK ACCEPTABLE YES NO

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE _____ S.S.# _____

DENTAL INSURANCE CO.: _____ GROUP NO: _____

Has any member of your family been treated in our office? yes no (When?) _____

Whom may we thank for referring you to our office? _____
 Dental referral Yellow Pages Website Billboard Mailer

FAMILY INFORMATION

HUSBAND (OR FATHER)				WIFE (OR MOTHER)			
LAST	FIRST	M.		LAST	FIRST	M.	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME PHONE #		WORK #		HOME PHONE #		WORK#	
BIRTHDATE M/D/Y		S.S.#		BIRTHDATE M/D/Y		S.S. #	
EMPLOYER				EMPLOYER			
DENTAL INSURANCE		GROUP #		DENTAL INSURANCE		GROUP #	

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
 Patient Husband (or Father) wife (or Mother) Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME: _____ Phone # _____
LAST FIRST

PAYMENT

Is Responsible Party currently a patient with this office? YES NO

Patient portion is due at time of service (check one). CASH CHECK CREDIT CARD

AUTHORIZATION

I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Reese to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

DATE: _____

Adult Patient Husband (or Father) Wife (or Mother) Guardian