PATIENT INFORMATION

DATE: _____

NAME_____ [ ]MARRIED [ ]SINGLE [ ]MINOR [ ]MALE [ ]FEMALE
LAST FIRST MI

ADDRESS_____
STREET APT# CITY STATE ZIP

BIRTHDATE_____TELEPHONE_____
MONTH DAY YEAR HOME # WORK #

EMAIL ADDRESS_____

DENTAL INSURANCE CO_____ GROUP #_____
PRIMARY INSURANCE COMPANY

PLACE OF EMPLOYMENT_____SS#_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

FAMILY INFORMATION

CHILD'S FATHER (OR PATIENT'S HUSBAND)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

_____
HOME # WORK# EXT.

_____
BIRTHDAY SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

CHILD'S MOTHER (OR PATIENT'S WIFE)

_____
LAST FIRST MI

_____
STREET CITY STATE ZIP

_____
HOME # WORK# EXT.

_____
BIRTHDAY SS#

_____
EMPLOYER

_____
DENTAL INSURANCE CO. GROUP #

AUTHORIZATION

I hereby authorize payment of the group insurance benefits to be paid to Providence Dental Group, LLc. The Information on this page and the medical/dental histories are correct to the best of my knowledge. I grant the right to release information about my dental treatment to my insurance carrier and other health professionals as needed during my treatment.

METHOD PAYMENT PLEASE CHECK ONE

[ ] Payment paid in full at each appointment
[ ] Payment of insurance co-payment at each appointment with the office receiving direct reimbursement from your insurance

X_____
SIGNATURE []Adult Patient []Father(Husband) []Mother(Wife) []Guardian

Who may we thank for referring you to our office?

_____

PERSON RESPONSIBLE FOR ACCOUNT

Please check one
[ ] Patient [ ] Father (or Husband)
[ ] Guardian [ ] Mother (or Wife)

Has the person responsible for the account been seen as a patient in our office?
[ ] Yes [ ]No