Getting Acquainted

Patient's name_____Social Security No._____

Home Address_____City_____Zip_____

Phone_____Date of Birth_____

Occupation_____Employer_____

Work Address_____Phone_____

Name of general dentist_____

Who may we thank for referring you to this office?_____

Single Widow/er Divorced Married

Spouse's name_____Date of Birth_____

Social Security No._____

Occupation_____Employer_____

Work Address_____Phone_____

Person responsible for payment of account:
Name_____

Please complete the following - if you have more than one insurance coverage, please list complete information for each:

Name of person carrying insurance_____

Social Security number_____

Name and address of employer_____

Name and address of insurance company_____

Name of union_____ Local No._____

Group plan_____ Policy No._____

Name of person carrying insurance_____

Social Security number_____

Name and address of employer_____

Name and address of insurance company_____

Name of union_____ Local No._____

Group plan_____ Policy No._____

I authorize and give you consent to perform dental services as agreed between us, doctor and patient (or doctor and parent/guardian), as necessary or advisable, including the use of local anesthesia and other medication as need indicates.

_____ _____
Signature of Patient, Parent or Guardian Date