# 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 No._____

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 No._____

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