PATIENT DENTAL RECORD

We are members of a team whose *primary job* is to serve you. Please don't hesitate to ask about anything you don't understand. *We* promise you will leave our office feeling taken care of.

Please complete *fully* and *print* legibly. All information, of course, will be held in strict confidence.

PATIENT HISTORY

Name_____Phone_____Email_____

Preferred Method of Communication ☐ Phone ☐ Text ☐ Email

Soc. Sec. No_____Birthdate_____Age_____Sex_____Martial Status_____

Address_____City_____State_____ Zip_____

Patient's Employer_____Work Phone_____

Person to notify in case of emergency_____Phone_____

Is any current dental problem the result of an accident ☐ Yes ☐ No If yes, when? _____

RESPONSIBLE PARTY'S INFORMATION

Person responsible for account _____
Last First Middle

Relationship to patient_____Home Phone_____Work Phone_____

Mailing Addresse_____City_____Zip_____

Soc. Sec. No._____Driver's License No._____

Employer _____Occupation _____

Employer's Address_____City_____Zip_____

Have you or any member of your family been a patient before? ☐ Yes ☐ No

Name_____ When? _____

Dental Insurance ☐ Yes ☐ No

Insured's Name_____Relationship_____

ID#_____ Birthdate _____

Employer _____

Insurance Company_____ Policy#_____

Secondary Insurance ☐ Yes ☐ No

Insured's Name _____Relationship_____

ID#_____ Birthdate _____

Employer_____

Insurance Company_____ Policy#_____

How did you hear about our office? ☐ Patient, name: _____ ☐ Insurance Provider List ☐ Health Fair

☐ Internet Search, site: _____ ☐ Other_____

Reason for today's visit? _____
check up, toothache, consultation, etc.

CONSENT

I, the undersigned, consent to performing of dental services and/or surgical procedures that may be decided upon to be necessary or advisable, and to the use of local anesthetic by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical/dental information to my insurance carrier for purposes of claims administration and evaluation, utilization review and audits. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s), the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I also understand that the amount quoted to me as any portion for dental services is an estimate only and may vary according to the limitations and policies of my particular dental insurance.

I agree to resolve any dispute through **arbitration** only. ***Initial:*** _____

_____ _____
Patient Date

_____ _____
Responsible Party Date