

## Patient Form

### ABOUT YOU

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Email:** \_\_\_\_\_ **May we contact you via email? (Please Circle) Yes No**

**Whom should we thank for referring you to our office?** \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Relationship of responsible party to patient:  Self  Spouse  Father  Mother  Guardian

**If responsible party is other than patient, please complete the remainder of this information.**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Consent: The undersigned hereby authorizes the Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk. I understand that my dental insurance is a contract between the insurance carrier, and me and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time of services rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balances.*

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Date