CONFIDENTIAL PATIENT INFORMATION Date:_____

I. Patient Information

Name:_____ Birthdate:_____ Gender: _____
Address:_____ City:_____ State:___ Zip Code:_____
Home Phone: _____ Cell Phone:_____ E-mail:_____
Social Security:_____ Driver's License:_____
Employer's Name:_____ Work Phone:_____

II. Responsible Party

Name:_____ Relationship to Patient:_____
Social Security #:_____Driver Lic #_____Birthdate:_____
Name of Employer:_____Phone:_____
Address:_____City:_____State: ___Zip Code:_____
Name of Insurance Company:_____Phone:_____
Union/Local:_____Group Number_____
Occupation:_____Date of Hire:_____

III. Second Insurance Information (Complete this section if patient is covered by another insurance company)

Name of the Insured:_____Relationship to Patient:_____
Social Security #:_____Driver Lic #_____ Birthdate:_____
Name of Employer:_____ Phone:_____
Address:_____City:_____State: ___Zip Code:_____
Name of Insurance Company:_____Phone:_____
Union/Local:_____Group Number_____

IV. Getting To Know You and Your Family

How did you hear about My Dentist?_____
Last dental x-rays taken?_____
When was your last dental visit?_____
What treatment was performed?_____

I understand and authorize My Dentist to verify and exchange information on myself or my spouse Including report from credit reporting agencies.
Signature _____Date_____

Please list all immediate family members:

Name:	Relationship:	Birthdate	Date of last dental visit

V. Emergency Contact (Friend or relative not living with you)

Name: _____Telephone: _____Relationship:_____
Name: _____Telephone: _____Relationship:_____

So we may bill your insurance directly, please sign.
I hereby authorize payment directly to My Dentist of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize dental care and release of any infonnation relating to this claim.

_____(Signature of the Insured)

FOR SIX MONTH RECALL ONLY
I hereby confirm there have been no changes to the above information.

Signature of the responsible party _____Date:_____