Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ **Date**:_____
Last First MI **Preferred Name**

Gender: ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ **Birth Date**:_____

Phone (Home): _____(**Cell):** _____**(Work):** _____ **Ext**:_____

E-mail Address: _____ Best time to call: _____

Preferred appointment times: ☐ A.M. ☐ P.M. ☐ Any Time ☐M ☐T ☐W ☐T

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ **Occupation:** _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Getting To Know You

Is a member of your family or a family friend a patient at our office? Yes No
Name: _____ Relationship: _____

Person to contact for emergency _____ Phone _____

Address _____
Street City IN Zip Code

Closest Relative not living with you _____Relationship_____

Phone _____Address _____
Street City State Zip Code

Your Former Address _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary- if applicable

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor or staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.

I understand that I can ask for a complete recital of any complications.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

May we welcome you by name in this month's office newsletter? YES NO