

Patient Information Form

Date of Appointment _____ Doctor _____

(please complete and return to receptionist)

NAME: Last First, Middle		<input type="checkbox"/> Male <input type="checkbox"/> Female		TODAY'S DATE	
ADDRESS: Street or PO Box		City		State Zip	
PHONE NUMBERS: Daytime		Nighttime		Other E-Mail Address	
DATE OF BIRTH		<input type="checkbox"/> Single <input type="checkbox"/> Married		SOCIAL SECURITY NO.	
OCCUPATION		EMPLOYER		PHONE NUMBER	
UNION & LOCAL					

Insurance Information

INSURED PERSON'S FULL NAME			DATE OF BIRTH		
SOCIAL SECURITY NO.		RELATIONSHIP TO PATIENT		WORK PHONE	
INSURANCE COMPANY NAME			PLAN/GROUP #		
EMPLOYER		FULL ADDRESS OF INSURANCE COMPANY			
DO YOU HAVE OTHER DENTAL INSURANCE?		INSURED PERSON'S FULL NAME			
DATE OF BIRTH		ADDRESS			
RELATIONSHIP			SOCIAL SECURITY NO.		
OCCUPATION		EMPLOYER		PHONE NUMBER	

Getting To Know You

1. Why did you select our office?
 - Union Letter
 - Union Office Receptionist (Name - Optional) _____
 - Union Representative (Name - Optional) _____
 - Family Member (Name - Optional) _____
 - Other _____
2. Is another member of your family or relative a patient in our practice? _____
3. Closest Living Relative: _____
 Relationship: _____ Phone: _____
 Reason for appointment: _____ Last dental visit/X-rays: _____

If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage your particular plan provides. We accept assignment of your insurance payment, another service to you. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

SIGNATURE OF RESPONSIBLE PARTY	RELATIONSHIP	DATE
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