DENTAL CARE ASSOCIATES

PATIENT INFORMATION

Last name: First: Middle:			What do you like to be called?
Birth date: / /	Age:	Sex: ❑ M ❑ F	❑ Single ❑ Married ❑ Minor
Street address:		Phone (H):	Phone (C):
City:	State:	Zip:	E-Mail:
Social Security #:		Occupation:	
Employer:		Phone (W):	Phone (other):
Other family members seen here:			
Whom may we thank for referring you to our office?			

INSURANCE INFORMATION

Name of person responsible for bill:	Check one: ❑ Patient ❑ Parent ❑ Spouse ❑ Other
Address (if different from patient):	
Dental Insurance Co.:	Group #:
Method of Payment: ❑ Insurance and co-payment ❑ Payment in full at visit	

FAMILY INFORMATION

Husband (or father if minor)		**Wife (or mother if minor)**	
Name:		Name:	
Address:		Address:	
Phone (H):	Phone (W):	Phone (H):	Phone (W):
Birth date: / /	SS#:	Birth date: / /	SS#:
Employer:		Employer:	
Dental Insurance Co:	Group #:	Dental Insurance Co:	Group #:

EMERGENCY CONTACT

Name of friend or relative (not living at same address):	Relationship	Home phone:	Work phone:

AUTHORIZATION / SIGNATURE OF RESPONSIBLE PARTY

IMPORTANT: We require a **24-hour notice** when canceling appointments. Failure to do so may result in a broken appointment fee. Your cooperation is greatly appreciated.

I hereby authorize Dental Care Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible for all costs of dental treatment. I authorize my insurance benefits be paid directly to the dentist. I also authorize Dental Care Associates or the insurance company to release any information required to process my claims. The above information and the medical history are true to the best of my knowledge.

X _____ _____

Patient/Guardian signature ❑ *Adult Patient* ❑ *Father* ❑ *Mother* ❑ *Guardian* *Date*