

PATIENT INFORMATION			Due form I M		
Last Name:	_ First Nam	e:	Preferre	Preferred Name:	
Street Address:					
City:					
Birth Date:	SSN#: _	E			
Home Phone:	Work Pho	ne:		Phone:	
Occupation:				Status:	
				☐ Single ☐ Married	
Referred By:				■ Minor ■ Other	
Person to Contact In An Emergency	y:		Phone:		
PREFERRED COMMUNICATION	METHOD				
Select all that apply:					
☐ Email ☐ Text Message (standard	=		=	-	
Do we have permission to contact y	you and leav	e messages on	your preferred	d communication	
method(s)? ☐ YES ☐ NO					
DDTMADY INCUDANCE					
PRIMARY INSURANCE			Dolation to D	ationt	
			Relation to Patient:		
SSN# Dri			Birth Date: Email Address:		
Work Phone: Mo		·		· · · · · · · · · · · · · · · · · · ·	
Insurance Carrier:				Union Local#:	
Employer Address					
Employer Address:					
ADDITIONAL INCURANCE					
ADDITIONAL INSURANCE	uranca) 🗆 \	/oc □ Nc			
Is Patient covered by additional ins Name of Insured:			Dolation to 5	Optiont	
			_ Relation to F	ratient:	
SSN# Bir	tn Date:				
Work Phone: Mo					
Insurance Carrier:				Union Local#:	
Employer:					
Employer Address:					
AUTUODIZATION FOR INCUR	NICE AND	CONCENT FOR	TOPATMEN	_	
AUTHORIZATION FOR INSURA					
I authorize my insurance company to services rendered and authorize the					
benefits. I understand that I am fina					
I hereby authorize doctor/staff to take X-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (or my child's) dental needs. Upon such					
deemed appropriate by doctor to ma diagnosis, I authorize doctor to perfo					
employ such assistance as required t					
other medication as necessary. I ful	ly understan	d that using anes	sthetic agents e		
understand that I can ask for a comp	olete recital c	of any possible co	omplications.		
v					
X Patient Signature Or Legal Guardia	n / Renrecei	ntative Signatur		Date	
radicine Digitalare Or Legal Guardia	11 / ICPLESE	reactive Digitalian	C	Dutt	