

Patient Information:

Name:				
First	Middle		Last	
Date of Birth://	Gender: Male	Female	Preferred Pronouns:	
Social Security Number:	Cell Pho	one: ()		
Home: ()	E-Mail:	····		
Home Address:				· · · · · · · · · · · · · · · · · · ·
(If Patient is a Dependent) Responsibl				
Name:	or unity innormation.			
First	Middle		Last	-
Date of Birth://	Gender: Male	Female	Preferred Pronouns:	
Cell Phone: ()	_ Home: ()	E-I	Mail:	
Home Address:				
Name of Primary Holder:	First	Middle	•	Last
Primary Holder's DOB://				
Insurance Company Name:				
Emergency Contact Information:				
Name of Local Friend or Relative:				_
	First		l ast	
Emergency Contact Phone Number: (_	First)		Last	
Emergency Contact Phone Number: (_	First)		Last	
Emergency Contact Phone Number: (_ Getting to Know You:	First)			
Emergency Contact Phone Number: (First) rch Engine [] Frien	d []Family []S		
Emergency Contact Phone Number: (_ Getting to Know You:	First) rch Engine [] Frien	d []Family []S		

FOR ALL PATIENTS

I 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 that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor/or his staff. I agree to pay for all services rendered by this office.

Signature:	 Date:	
O.g. iata. c.	 	