

PATIENT INFORMATION

Today's Date: _____

Name: _____
Last Name First Name Middle Initial Preferred Name

Single Married Minor Male Female

Birth date _____ Telephone _____
Month Day Year (Area code)+Home (Area code)+Work (Area code)+Fax (Area code)+Pager

Home Address: _____
Street City State Zip

Occupation: _____ Social Security # _____

If full time student, name of school: _____

**Person responsible for account
Please Check One ->**

Patient Guardian Spouse Father Mother

**INSURANCE
INFORMATION**

Minor Children: May need to complete both blocks for responsible party information
Adults: Complete primary insured, if dual coverage, complete secondary insurance also

Has any member of your family ever been treated in our office? yes no
Does the responsible party have a current account with this office? yes no

PRIMARY INSURED ~ If No Insurance Complete for responsible party

SECONDARY INSURED ~ If No Insurance Complete for responsible party

Last name	First name	Middle initial
Street	City	State Zip
Home Phone	Work	Fax Pager
Relationship to Patient	Birth Date	Social Security #
Employer:	_____	
Address:	_____	
Dental Insurance Company:	_____	
Address:	_____	
Group#	Policy#	Subscriber#
Insurance Phone#	_____	

Last name	First name	Middle initial
Street	City	State Zip
Home Phone	Work	Fax Pager
Relationship to Patient	Birth Date	Social Security #
Employer:	_____	
Address:	_____	
Dental Insurance Company:	_____	
Address:	_____	
Group#	Policy#	Subscriber#
Insurance Phone #	_____	

**PERSON TO CONTACT
IN CASE OF EMERGENCY**

Outside of Immediate Family Household

Name _____ Phone # _____
Street _____
City, State, Zip _____

**REFERRAL
INFORMATION**

Who May We Thank For Referring You To Our Office?

Name: _____
 family friend co-worker

I hereby authorize Kehrs Mill Dental Arts, its doctors, employees, agents, and assistants to perform dental procedures on me. The purpose of these dental procedures is to alleviate my dental problems.

I acknowledge and understand that these dental procedures, or course of procedures, do not always produce a desired, expected, or successful result, and that no guarantees can or have been made concerning the results of these procedures.

I acknowledge that full and complete disclosure of the benefits of completing treatment and the consequences of not doing treatment along with reasonable known risks have been discussed with me and that all of my questions have been answered in a satisfactory manner.

Signature/Patient: _____ Signature/Responsible Party: _____