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