# PATIENT INFORMATION

**DATE** ___________________________

**NAME** _______________________________________________
LAST FIRST M.I.

☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

**ADDRESS** ________________________________________________________________________________________________________
STREET APT # CITY STATE ZIP

**BIRTHDATE** _________________________________ **TELEPHONE** ___________________________________________________________________
MONTH DAY YEAR HOME# WORK# CELL #

**PLACE OF EMPLOYMENT** ______________________________________________________ **SS#** ___________________________________________

**IF FULL TIME STUDENT, SCHOOL NAME** ___________________________________________________ **GRADE** ___________________________

**HOW DID YOU HEAR ABOUT OUR OFFICE?** ☐ **INSURANCE** __________________ ☐ **FAMILY/FRIEND** _________________________
☐ **PHONE BOOK** ☐ **OTHER** _______________________________________________

**PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE:** ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

# INSURANCE INFORMATION

| **PRIMARY INSURED** IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY | **SECONDARY INSURED** IF APPLICABLE |
|---|---|
| LAST FIRST M | LAST FIRST M |
| STREET CITY STATE ZIP | STREET CITY STATE ZIP |
| HOME # WORK # | HOME # WORK # |
| BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT | BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT |
| EMPLOYER DENTAL INSURANCE CO | EMPLOYER DENTAL INSURANCE CO |
| SS# SUBSCRIBER # GROUP# | SS# SUBSCRIBER # GROUP# |

# PERSON TO CONTACT IN CASE OF EMERGENCY

**NAME** ____________________________________________________ **TELEPHONE #** _____________________________________________________

**ADDRESS** _________________________________________________ **CITY/STATE/ZIP** __________________________________________________

# AUTHORIZATION

I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Dr. Frank Harmon and Dr. Carter Davis's office. I understand that I am responsible for all costs of dental treatment, regardless of dental insurance reimbursement. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals as deemed necessary to perform treatment, payment, and/or healthcare operations by Dr. Harmon, Dr. Davis, and the staff.

X _______________________________________________ _______________________________________________
Signature of patient or responsible party Date