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