# Patient Information

Name:_______________________________________________________________________________

Address:_____________________________________________________________________________

City:____________________________________________State:__________ Zipcode:______________

Sex: M F Age:_______D.O.B.__________ SS#_____________________ Marital Status: S M D W

DL#_____________________State of Issue:______________ (Staff Initials-id verified-______________)

Cell #:_____________________Home #:____________________Work #:_________________________

Email:_____________________________________

*If Applicable :Parent/Guardian Name*_____________________________*Relationship*____________________

*Address if different* _____________________________________________________________________

In Case of Emergency:_______________________Contact #:____________________________________

Whom may we thank for referring you?_____________________________________________________

## Authorization

It is the patient's responsibility to know and understand their insurance coverage. We will not be held responsible for charges that are not covered by the patient's insurance plan. I authorize my dentist to release necessary information to secure payment of benefits. I understand that after 30 days, I am financially responsible for all charges whether or not paid by my insurance plan. We realize emergencies can occur. However, should an unforeseen situation prevent you from making your pre-arranged appointment, please contact our office with at least 24 HOURS NOTICE, to avoid the possibility of a cancellation fee ($50.00).

**Signature**:____________________________________ **Date:**___________________________________