Date ______________________

Patient Information (CONFIDENTIAL)

Please circle:

Name ______________________ **Male** **Female** Soc. Sec.# ______________

Email ______________________ Birthdate ______________ Home Phone ______________

Address ______________________ City ______________ State ______ Zip ______

Circle appropriate: Minor Single Married Divorced Widowed Separated Cell Phone ______________

Patient's or Parent's Employer ______________________ Work Phone ______________

Business Address ______________________ City ______________ State ______ Zip ______

Spouse or Parent's Name ______________ Employer ______________ Work Phone ______________

If Patient is a student, name of school/college ______________________ City ______________ State ______

How did you hear about us? ______________ Reason for leaving last dentist ______________

Person to contact in case of emergency ______________ Relationship ______________ Phone ______________

Has any other family member been in office? YES NO If yes, name: ______________________

Responsible Party

Relationship to Patient: *(circle one)*

SELF **SPOUSE**

CHILD **OTHER**

Name of Person responsible for this Account ______________________

Address ______________________

Driver's License # ______________ Birthdate ______________ Home Phone ______________

Employer ______________________ Work Phone ______________

Is this person currently a patient in our office? YES NO

Insurance Information

ID# ______________________

Relationship to Patient: *(circle one)*

SELF **SPOUSE**

CHILD **OTHER**

Name of Insured ______________________

Birthdate ______________ Soc. Sec. # ______________

Name of Employer ______________________ Work Phone ______________

Address of Employer ______________________ City ______________ State ______ Zip ______

Insurance Company ______________________ Group # ______________

Ins. Co. Address ______________________ City ______________ State ______ Zip ______

• Do you have additional insurance? YES NO *If yes, please complete the following:* Relationship to Patient: *(circle one)*

SELF **SPOUSE**

CHILD **OTHER**

Name of Insured ______________________

Birthdate ______________ Soc. Sec. # ______________

Name of Employer ______________________ Work Phone ______________

Address of Employer ______________________ City ______________ State ______ Zip ______

Insurance Company ______________________ Group # ______________

Ins. Co. Address ______________________ City ______________ State ______ Zip ______

Consent

• I understand hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

• I understand and authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ______________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

• I understand that is a minor of my responsibility is being treated for any dental service that an authorized adult must stay on the premises at all times during the reserved appointment time. I also understand that if an adult or minor is being treated for dental services, no other minors will be allowed to accompany them during treatment.

• I understand that it is my responsibility to advise and notify Southwest Dental Group of any changes in the information contained on this form.

• To the best of my knowledge the information on both sides of this form is true.

Patient ______________________ Date ______________ Witness ______________

Parent or Responsible Party ______________________ Relationship to Patient ______________