PATIENT INFORMATION

Name _____ Date _____

Social Security_____ Date of Birth _____

Address_____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-Mail _____

Single _____ Married _____ Widowed _____ Separated _____ Minor _____

INSURANCE INFORMATION

If you do not have dental insurance please check this box and skip this section

Dental Insurance _____

Employer of Insured _____

Spouse/Parent/Guardian Name _____

Insured Date of Birth _____ Insured Social Security/Member ID _____

Emergency Contact _____

Whom may we thank for referring you:

Google

Yelp

Insurance Referral

Radio : _____

Patient Referral: _____

Dentist Referral: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X _____ Date: _____

MEDIA RELEASE

I authorize the use of my photos or cases for educational and marketing purposes for Major Dental Clinics.

Signature

X_____ Date: _____