Dentaluxe

Today's Date _____/_____/_____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called. _____

Sex □ M □ F Date of Birth _____/_____/_____ □ Single □ Married □ Widowed □ Divorced

Home Address _____
Street City State Zip

Phone # (_____) _____ (_____) _____ (_____) _____
Home # Work # Ext# Mobile #

Social Security # _____ E-mail Address _____
(**Please note**- if you choose not to provide your SS#, we must collect the full payment- in the form of cash- at each visit and cannot bill your insurance carrier on your behalf. However, we are happy to print a claim that you may submit to your insurance carrier for reimbursement.)

What is your preferred method of contact regarding your upcoming dental appointments? Text □ / Email □ / Phone Call □

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? □ Yes □ No If so, who? _____

Contact in case of emergency _____ (_____) _____
Name Relationship Phone #

□ Spouse *or* □ Parent, if minor _____ (_____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card *or* please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (_____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____

Date _____