

PATIENT INFORMATION			
Patient's Last Name	First	M.I.	Home Phone# ()
Patient's Street Address	Apt#	City	State/Zip Code
Sex <input type="checkbox"/> Male	Birthdate	Age	Social Security#
<input type="checkbox"/> Female	Month-Day-Year		
Patient's Employer		Spouse's Employer	
Employer Address	Business Phone# ()	Employer Address	
Person Responsible for Account			Relationship
Address			Phone# ()
Where did you hear about us?			
Who referred you to our office?			
Emergency Contact			Phone# ()
GENERAL DENTIST			
DENTAL INSURANCE INFORMATION			
Primary Insurance Information		Secondary Insurance Information	
Policyholder's Name	Date of Birth	Policyholder's Name	Date of Birth
Name of Insurance Company		Name of Insurance Company	
Address		Address	
Group Number	Social Security #	Group Number	Social Security #
Insurance Company's Phone Number		Insurance Company's Phone Number	
AUTHORIZATION			
<p>I hereby authorize payment directly to the dentist from the insurance company for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I hereby authorize the dentist to perform any and all forms of treatment that may be indicated in connection with endodontic care of the above patient.</p>			
SIGNATURE			DATE