Patient Information

Thank you, for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name: ________________________________ **SS#** ____________
Last First MI
Address: ________________ **City:** __________ **State:** ______ **Zip:** ______
Birthdate: __________ **Place of Birth** ______________ **Age:** ______
Home Phone: __________ **Cell Phone:** __________ **Work Phone:** __________
Do you prefer to receive calls at: **Home** **Work** **Either**
Are you: **Minor** **Married** **Single** **Divorce** **Separated** **Widowed**

You or your parent's employer ______________ **Occupation:** __________
Business Address: ______________ **City:** __________ **State:** ______ **Zip:** ______
Spouse's or Parent's Name: __________ **Workplace:** __________ **Work Phone:** ______
If you are a student, name of school/college: ______________ **Phone:** ______
Whom may we thank for referring you to us? ______________
Person to contact in case of emergency: ______________ **Phone:** __________

Responsible Party

(Need copy of Insurance card)

Name of person responsible for this Account? ______________
Relationship to Patient: ______________ **Phone:** ______________

Mailing Address: ______________ **City:** __________ **State:** ______ **Zip:** ______
Name of employer: ______________ **Work Phone_:** ______________

Dental Insurance Information

No — Yes ***IF YES, Please complete the following:***

Insurance Co.: ______________ **Group:** __________
Insurance Co. Address: ______________ **City:** __________ **State:** ______ **Zip:** ______

Name of insured: ______________ **Relationship to Insured:** ______________
Birth date: __________ **Social Security:** __________ **Member ID:** __________
Name of employer: ______________ **Work Phone:** ______________
Address: ______________ **City:** __________ **State:** ______ **Zip:** ______

ADDITIONAL DENTAL INSURANCE? NO - YES IF YES, Please complete the following:
Insurance Co.: ______________ **Group:** __________ **Employer:** __________
Insurance Co. Address: ______________ **City:** __________ **State:** ______ **Zip:** ______

Name of insured: ______________ **Relationship to insured:** ______________
Birthdate: ______ **Social Security:** ______________ **Member ID:** __________
Name of employer: ______________ **Work phone:** ______________
Address: ______________ **City:** __________ **State:** ______ **Zip:** ______

(Need copy of Insurance card)

I hereby authorize Dr. Sutton and the entire staff to administer any treatment including x-rays and anesthetics and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize release of any information including the diagnosis and records of any treatment for my child or me during the period of such dental care to third party payers. I realize that I am ultimately responsible for all cost of treatment I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand the use of anesthetic agents embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to the practice and provide any of my record need to the insurance.

DATE: __________ ***SIGNATURE:*** ***(Patient or Guardian)*** ______________________