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(479) 442-5092

PATIENT INFORMATION *(Please completely fill out front and back of this form)*

Patient's Full Name: _____ Name you like to be called: _____
First, Middle, Last

Patient's Address: _____
Street *Apt . #* *City* *State* *Zip*

Home Phone: (_____)_____ Cell Phone: (_____)_____ E-Mail Address:_____

SS#: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Male ☐ Female Date of Brith ____/____/____ Age _____(years) _____(months) Height _____ Weight _____

Place of Employment or School: _____ Work Phone: (_____)_____

Person to contact in case of emergency: _____ Phone: (_____)_____

Contact's Address: _____

Names and ages of children or siblings: _____

Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: _____ Relationship to Patient: _____
First, Middle, Last

Full Home Address: _____
Street *Apt. #* *City* *State* *Zip*

Home Phone: (_____)_____ Cell Phone: (_____)_____ E-Mail Address:_____

SS#: _____ ☐ Male ☐ Female Date of Brith ____/____/____

Place of Employment or School: _____ Work Phone: (_____)_____

Employer's Address: _____

Secondary Responsible Person:

Full Name: _____ Relationship to Patient: _____
First, Middle, Last

Full Home Address: _____
Street *Apt #* *City* *State* *Zip*

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

DENTAL INSURANCE INFORMATION *(If you have insurance, this section must be completed)*

Name of Dental Insurance Company: _____ Group # _____
Address in which to mail claims: _____
Name of Subscriber: _____ ID#_____ Relationship to patient: _____

Name of Secondary Dental Insurance Company: _____ Group # _____
Address in which to mail claims: _____
Name of Subscriber: _____ ID#_____ Relationship to patient: _____

RELEASE

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.
I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.
I consent to the release of credit reports and information regarding my credit history to the doctor(s).
I authorize the taking of photographs, radiographs and other diagnostic records before, during, and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Patient or Guardian's Signature: _____ Date: _____