

## PATIENT INFORMATION

Name \_\_\_\_\_  Married  Single  Minor  Male  Female  
Last First MI

Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt# City State Zip

Birthdate \_\_\_\_\_  
Month Day Year

Telephone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Home # Work # Cell#

Employer \_\_\_\_\_

Person Responsible for Account  Patient  Guardian  Spouse  Father  Mother

## INSURANCE INFORMATION

PRIMARY INSURANCE OR RESPONSIBLE PERSON	SECONDARY INSURANCE
Name _____	Name _____
Street City State Zip	Street City State Zip
Home # Work # Cell#	Home # Work # Cell#
Birthdate (Month/Day/Year) Relationship to Patient	Birthdate (Month/ Day/ Year) Relationship to Patient
Employer Dental Insurance Co	Employer Dental Insurance Co
Social Security # Subscriber # Group #	Social Security # Subscriber # Group #

### PERSON TO CONTACT IN CASE OF EMERGENCY

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_

Telephone #s \_\_\_\_\_

*Who can we Thank for referring you to our office?*

\_\_\_\_\_

*or*

*How did you hear about Dr. Adams ?*

\_\_\_\_\_

### AUTHORIZATION

The information on this page and the medical/dental histories are correct to the best of my knowledge. I grant the right to Dr. Adams' office to release my dental/medical histories and other necessary information about my dental treatment to third party payors and /or other health professionals. I authorize payment directly to Dr. Adams by my insurance carrier otherwise payable to me. **I understand I am responsible for all costs of dental treatment.** I hereby authorize Dr. Adams to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.

**X** \_\_\_\_\_  
Patient Signature or Responsible Party

\_\_\_\_\_  
Date