Dental Touch .com associates

PATIENT INFORMATION

Name________________ Social Security Number________________

Address________________ City________________ State________ Zip________

Home Phone________________ Cell Phone________________ Sex M ☐F ☐ Birth Date________________

Patient Employed by________________ Occupation________________ Work Phone________________

Business Address________________ City________________ State________ Zip________

Business Phone________________ Emergency Contact________________ Phone________________

Person Responsible for account________________ Relationship________________ Marital Status________

WHOM MAY WE THANK FOR REFERRING YOU?________________ ________

DENTAL INSURANCE INFORMATION

Do you have dental insurance? Yes________ No________ Subscriber Name________________

Social Security Number________________ Birth Date________________ Relationship to patient________________

Employed by________________ BusinessAddress________________ Business Phone________________

Dental Insurance Company________________ Insurance Address________________

Insurance Phone________________ Group #________________ Subscriber #________________

Are you covered by another Dental Insurance Plan? Yes________ No________ Subscriber Name________________

Social Security Number________________ Birth Date________________ Relationship to patient________________

Employed by________________ Business Address________________ Business Phone________________

Secondary Dental Insurance Company________________ Insurance Address________________

Insurance Phone________________ Group #________________ Subscriber #________________

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thourough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that I am financially responsible for all charges whether or not paid by insurance. These fees are due and payable at the time of service. I also assign all insurance benefits to the Doctor.

PATIENT, PARENT OR GUARDIAN SIGNATURE________________________________ DATE________________