PATIENT INFORMATION

GENERAL INFORMATION:

DATE_______________

NAME____
(Last) (First) (Middle) (Preferred Name)

HOME ADDRESS____
(Street)

____
(City) (State) (Zip)

SOCIAL SECURITY NUMBER_______________ MARITAL STATUS M S W D

HOME PHONE________________ WORK PHONE________________ CELL PHONE_________________

DATE OF BIRTH_______________ GENDER_______________

____
EMERGENCY CONTACT (NAME AND PHONE NUMBER)

EMAIL ADDRESS _________________________________ MAY WE: EMAIL _____TEXT_____

REFERRED BY___________________________________

EMPLOYMENT INFORMATION:

EMPLOYED BY___________________________________ OCCUPATION_____________________________

DENTAL INSURANCE INFORMATION:
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

POLICY HOLDER'S NAME ________________________ RELATIONSHIP TO PATIENT___________________

DATE OF BIRTH_____________________________ SOCIAL SECURITY NUMBER_____________________

EMPLOYER___________________________________

INSURANCE COMPANY____
(Name) (Address)

GROUP PLAN #____________________INSURANCE IDENTIFICATION NUMBER_______________________

I hereby authorize payment directly to BlueWave Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all fees for professional services that are rendered. I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for my dental care. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form and the medical history. The information on this page and the medical history are correct to the best of my knowledge.

Signature of Patient/ Responsible Party _______________________________________**Date**__________