Patient Information

Social Security # _____

Patient name _____ Date of birth _____

Address _____ Home phone _____

City, State, Zip code _____ Work phone _____

Email _____ Cell phone _____

Sex M F Marital status S M W D SEP Spouse's name _____

Patient's employer _____ Occupation _____

Individual Information

If you have a family member or relative who is a patient of our practice, please tell us who.

Name _____ Relationship to patient _____

Whom may we thank for referring you to our office? _____

In case of an emergency, whom should we contact on your behalf?

Name _____ Relationship to patient _____

Address _____ Phone _____

Financial Information

Person financially responsible for this account _____

Address _____ Home phone _____

City, State, Zip code _____ Work phone _____

Social Security number _____ Relationship to patient _____

Employer _____ Occupation _____

Dental Insurance Information

Primary Carrier	Secondary Carrier
Insurance company _____	Insurance company _____
Employer _____	Employer _____
Insured's name _____	Insured's name _____
Insured's date of birth _____	Insured's date of birth _____
Insured's relationship to patient _____	Insured's relationship to patient _____
Insured's Social Security number _____	Insured's Social Security number _____

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to David C. Wood, D.D.S.

Signature of insured / employee _____ Date _____

Financial Responsibility

I affirm that the information provided on this form is complete and accurate to the best of my knowledge. I understand I am responsible for the payment of all fees for dental services provided to me (or to the patient named above).

Signature of patient _____ Date _____

(or)

Signature of parent or responsible party _____ Date _____

Relationship to patient _____

Please complete other side