Date ______________________

Patient's Name _______________________________________ Birthdate ____________ Single ___

Name of Spouse _______________________________ Spouse's Phone _____________ Married ___

If Child, Parent's Name ____ Divorced ___

Street Address ______________________________________ State ___ Zip _______ Separated ___

Email Address ____

Mailing Address ____ State ___ Zip _______

Home Phone _____________ Work Phone _____________ Cell Phone _____________ Text: **Y** / **N**

How did you hear about us ____

Employer ____

Work Address ____

Spouse's Employer____ Work Phone ______________________________

Purpose of this Appointment ____

Emergency Contact ____ Contact Number _________________________

Who Is Responsible for this Account ____

Insurance company ____ Group Number __________________________

Secondary insurance ____ Group Number __________________________

Social Security # ________________ Birthdate (if different) _____________ Relationship to Patient ____________________

Persons we can discuss your account with: ____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also give my consent to Sheppard Family Dentistry to use my dental photograph, photograph, video, slides, or any other image without my name for educational purposes and in promoting cosmetic dentistry.

Signature ____ ***Date*** ________________