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**_____