Who referred you to this office ______________ Social Security # _________________Today's Date _________

Patient's Name ____ Birthdate ___________________

Address ____ City ______________ ST_____ ZIP ______________

Home Phone ______________________ Work Phone ______________________ Ext _____________

Cell Phone _____________________ Pager __________________ E-Mail _________________________

Employer _________________________________ City ______________ Occupation __________________

Name of Parent /Partner/ Spouse / Guardian _________________________ Birthdate_______________
(circle one)
Social Security # ____________________________

Address if different_______________________________ City___________ ST_____ ZIP ______________

Home Phone __________________________ Work Phone___________________ Ext______________

Employer ___________________________________City _______________ Occupation ___________________

In case of emergency, whom shall we notify other than spouse?

Name _________________________ Relationship ______________ Phone ___________________________

<u>DENTAL</u> INSURANCE INFORMATION

EMPLOYEE NAME ______________________________

INS CO NAME_________________________________

INS CO ADDRESS ______________________________

INS CO CITY, ST, ZIP___________________________

INSURANCE PHONE ____________________________

GROUP / POLICY # _____________________________

SUBSCRIBER ID # ______________________________

BIRTHDATE ___________________________________

<u>DENTAL</u> INSURANCE INFORMATION

EMPLOYEE NAME ______________________________

INS CO NAME_________________________________

INS CO ADDRESS ______________________________

INS CO CITY, ST, ZIP___________________________

INSURANCE PHONE ____________________________

GROUP / POLICY # _____________________________

SUBSCRIBER ID # ______________________________

BIRTHDATE ___________________________________

Patient Acknowledgments:

- I understand that all charges incurred are payable in full at the time of service.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I consent to the publication of my photos released to Dr. Reddick by any other healthcare providers.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature ____ Date _____________________
Parent or Guardian if a minor

PATIENT INFORMATION