

RAY DENTAL GROUP

DATE _____

PATIENT INFORMATION

NAME _____ CHILD _____ MALE _____ FEMALE _____
ADDRESS _____ MARRIED _____ SINGLE _____
CITY _____ STATE _____ ZIP CODE _____
SOC.SEC.# _____ BIRTHDATE _____ E-MAIL _____
HM PHONE _____ WK PHONE _____ CELL PHONE _____ OTHER _____
EMPLOYER _____ IF FULL TIME STUDENT SCHOOL NAME _____
OTHER FAMILY MEMBERS PATIENTS HERE? YES NO IF YES WHO? _____
RELATIONSHIP TO PATIENT _____ ARE YOU TO BE ADDED TO THEIR ACCOUNT? _____

FAMILY INFORMATION

REFERRED TO OUR OFFICE BY _____

PARENT OR GUARDIAN IF PATIENT IS A MINOR

NAME _____
ADDRESS _____
CITY _____
HM PHONE _____ WK PHONE _____
BIRTHDATE _____ SOC SEC # _____
EMPLOYER _____

SPOUSE OR OTHER PARENT

NAME _____
ADDRESS _____
CITY _____
HM PHONE _____ WK PHONE _____
BIRTHDATE _____ SOC SEC # _____
EMPLOYER _____

DENTAL INSURANCE

SUBSCRIBER'S NAME _____
SOC.SEC# _____
BIRTH DATE _____
INSURANCE CO _____
GROUP # _____
PHONE # _____

EMERGENCY CONTACT

NAME _____
ADDRESS _____
PHONE _____

**DUE TO LENGTH OF DELAYS WE CAN NO LONGER
FILE YOUR SECONDARY INSURANCE**

AUTHORIZATION

I hereby authorize RAY DENTAL GROUP to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for dental treatment, and to release my dental/medical histories, if needed for treatment to other health care professionals.

I authorize RAY DENTAL GROUP to furnish information to my insurance company concerning my dental conditions and treatments, and assign all payments from insurance to RAY DENTAL GROUP. I understand that I will pay my insurance deductible and co-pay at the time of treatment.

I understand I will be responsible for any balance that insurance does not cover.

PATIENT
SIGNATURE _____ DATE _____

Updated _____ Updated _____ Updated _____ Updated _____ Updated _____ Updated _____