Date: **Chart #**

Patient's Name: _____ SS# _____
LAST FIRST MI

Preferred Name: _____ Date of Birth: / / Age: _____

Mailing Address: _____

_____
CITY STATE ZIP

DL#: _____ ____ Marital Status (circle one): S M D Sex: F M

Home #: ( ) Work #: ( ) Cell #: ( )

Email Address: _____

Employer: _____

Position:_____ Supervisor: _____

Spouse/Guardian

Spouse/Guardian Name_____ SS#_____ Date Of Birth_____

Spouse Address_____ City_____ ST____ ZIP_____

Spouse Employment_____Work#_____Ext_____ Home#_____

Dental Insurance: YES NO

Patient's Carrier_____ Spouse's Carrier _____

Patient's SS# _____ Spouse's SS# _____

Group #_____Spouse's Group# _____

WHO REFERRED YOU?_____REGULAR DENTIST_____

HAVE WE EVER TREATED ANY OF YOUR IMMEDIATE FAMILY?_____IF YES, NAME_____

IN CASE OF EMERGENCY NOTIFY_____PHONE#_____RELATIONSHIP_____

NEAREST RELATIVE NOT LIVING WITH YOU_____PHONE#_____

CONSENT

I attest that the information I have provided is accurate and complete. Any changes in health status or medications will be reported to Dr. Mike Robertson and/or his staff at the next dental visit following the change. In addition I authorize Dr. Robertson and/or staff to take radiographs, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I understand that the use of anesthetic agents embodies a certain risk**. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. Any payments received from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred**. I authorize Dr. Mike Robertson to release information to my insurance company and to file insurance claims as my treatment progresses. I authorize payment directly to Dr. Mike Robertson of the group insurance benefits otherwise payable to me. I further understand that a finance charge will be added to any overdue balance**. I understand any balance remaining after dental insurance has paid is due and payable with in 10 days.**

_____ _____
Date **Patient Signature**