



RENAISSANCE DENTISTRY

Patient Information

Patient Name: _____ Preferred Name: _____

First MI Last
Male Female Married Single Child Other _____

Soc. Sec. #: _____ DOB: _____ Drivers Lic. # _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

E-mail: _____ I would like email correspondence Y/N

Home Address: _____

Street Apartment #

City State Zip Code

Employer Name: _____ Position: _____

Please list any family members who are patients in our office:

Referral Information

May we thank someone for referring you? Or did you find us on your own? How?

Date of Last Dental Visit: _____ Date of Last Dental rays: _____

Name and Phone number of previous dentist: _____

For what reason do you come to our office today?

If you could improve your smile, what would you change?

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No

Last First MI
Insured's Social Security #: _____ Birth Date: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Dental insurance company name: _____

If you have insurance, we will accept your coverage as a form of payment. You are responsible for deductibles, co-payments, and any balances that may not be covered by your insurance company at the time of service.

I grant my permission to telephone me at home Yes/No (circle) and at work Yes/No (circle) to discuss matters related to this form. If you would like us to file your insurance claim, please initial below to authorize the release of information necessary to process your claim and collect payment. _____ Initials

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions and agree to their content.

Patient's Name _____ Responsible Party _____

Signature of guarantor _____ Relationship to Patient _____ Date _____