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 _____

DENTAL INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME _____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

SUBSCRIBER ID # _____

BIRTHDATE _____

DENTAL 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. Kinzer or Spear 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