



1747 South Heritage Lane, Suite B203 • Syracuse, Utah 84075 • 525-1725

DATE

PATIENT INFORMATION

LAST NAME		FIRST NAME		M.	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Minor	
ADDRESS				UNIT #	<input type="checkbox"/> Male <input type="checkbox"/> Female	
CITY		STATE/ZIP		BIRTHDATE (Month, Day, Year)		
HOME PHONE		WORK PHONE		FAX		
SOCIAL SECURITY NUMBER			E-MAIL ADDRESS			
PLACE OF EMPLOYMENT						
IF FULL-TIME STUDENT SCHOOL NAME			GRADE	PERSON RESPONSIBLE FOR ACCOUNT		

PERSON TO CONTACT IN CASE OF EMERGENCY

LAST NAME		FIRST NAME		HOW RELATED		
ADDRESS				UNIT #	<input type="checkbox"/> Male <input type="checkbox"/> Female	
CITY		STATE/ZIP		E-MAIL ADDRESS		
HOME PHONE		WORK PHONE		FAX		

REFERRALS

<p>Has any member of your family ever been treated in our office? YES NO</p> <p>Whom may we thank for referring you to our office?</p> <p>_____</p>

AUTHORIZATION

<p>I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.</p>	
<p>_____</p> <p>PATIENT or RESPONSIBLE PARTY</p>	<p>_____</p> <p>DATE</p>

