Market Place Dentistry

All About You

Name of Patient:_____ Dr./Mr./Mrs./Ms/Miss
Nickname:_____ E-mail Address:_____ Birthdate:_____
Address:_____
City_____ State_____ Zip Code_____
Telephone *home:*_____ *work:*_____ *alternate:*_____
Occupation:_____ Employer:_____
If a student, name of school:_____
Social Security Number:___-___-____ Driver's License Number:_____
Whom may we thank for referring you to us?_____
Spouse's Name:_____ Occupation:_____
Emergency Contact:_____ relationship:_____ telephone:_____
Emergency Contact Address:_____
Responsible Party:_____ Dr./Mr./Mrs./Ms/Miss
Home Address:_____
Telephone *home:*_____ *work:*_____ *alternate:*_____
Occupation:_____ Employer:_____
Employer Address:_____
Social SecurityNumber:___-___-____ Driver's License Number:_____
Birthdate:_____ Relationship to patient:_____

Insurance Company #1_____
Insurance Company #1 Address:_____
Policyholder's Name:_____ Relationship to Patient:_____
Social Security Number:___-___-____ Birthdate:_____
Group/Policy Number:_____ Certificate Number:_____
Employer:_____ Hire Date:_____
Insurance Company #2_____
Insurance Company #2 Address:_____
Policyholder's Name:_____ Relationship to Patient:_____
Social Security Number:___-___-____ Birthdate:_____
Group/Policy Number:_____ Certificate Number:_____
Employer:_____ Hire Date:_____

(If a third insurance policy number is applicable, please notify us.)

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, diagnostics, medication administration, and therapy, that may be indicated in connection with the oral healthcare of the patient above. Further, I authorize and consent that the doctor chooses and employs such assistance as he/she deems appropriate. Also, I understand that prior to treatment, an explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by Market Place Dentistry.

_____ Date:_____
Signature of Patient/Responsible Party/Conservator

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