**DENTAL CHART**

**CONFIDENTIAL – COMPLETE FULLY – PLEASE PRINT**

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| LAST NAME OF PATIENT FIRST MIDDLE INITIAL |  Married Divorced Single Widowed | HOME #:CELL #: |
|  Male Female |
| HOME ADDRESS OF PATIENT CITY ZIP | BIRTH DATE | AGE | SS#: |
| PARENT NAME (IF PATIENT IS A MINOR) | OCCUPATION OF PATIENT/SCHOOL NAME |
| EMPLOYER (PARENT IF MINOR) ADDRESS CITY ZIP | TELEPHONE AT WORK |
| SPOUSES’ EMPLOYER ADDRESS CITY ZIP | TELEPHONE AT WORK |
| DO YOU HAVE DENTAL INSURANCE: YES NO INSURED MEMBER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME OF DENTAL INSURANCE COMPANY #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER I.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP NO.\_\_\_\_\_\_\_\_\_\_\_\_INSURED MEMBER’S SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COMPANY #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER I.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INSURED MEMBER’S SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDI-CAL I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW DID YOU HEAR ABOUT US:  Referred – by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Magazine/Newspaper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_ On-Line:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brochure / Flyer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW LONG SINCE YOUR LAST VISIT TO A DENTI­ST?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHY ARE YOU HERE TODAY? TOOTHACHE ESTIMATE CHECK-UP OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_ |
| I HEREBY GRANT AUTHORITY TO THE DENTIST(S) IN CHARGE OF THE PATIENT WHOSE NAME APPEARS ON THIS FORM TO ADMINSTER ANESTHETICS AND PERFORM SUCH PROCEDURES DEEMED NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF THIS PATIENT. I THE UNDERSIGNED SHALL BE RESPONSIBLE FOR THE PAYMENT OF CHARGES INCURRED FOR THE SERVICES RENDERED AND SHALL BE RESPONSIBLE FOR PAYMENT IN EXCESS OF EXISTING INSURANCE COVERAGE. ALSO PERMISSION IS GRANTED TO PERFORM NECESSARY TREATMENT IF PATIENT IS A MINOR.PATIENT’S SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |