NEW PATIENT ACQUAINTANCE FORM

PERSONAL INFORMATION

Patient Name ______________________________ Male/Female Birthdate __________

If a child, Parent's Name ______________________________ Birthdate __________

Street Address ____

City ______________ State ______ Zip _______ Phone ______________

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed Mobile Phone ____________

Name of Spouse ______________________________ Birthdate __________

EMPLOYMENT INFORMATION

Patient's Employer ______________________________ Phone ____________

Address ____

Spouse's Employer ______________________________ Phone ____________

Address ______________________________ Birthdate ____________

FINANCIAL INFORMATION

Person Responsible: ❑Patient ❑Parent ❑Spouse ❑Other ______________________

SS# ______________________ Drivers License # ____________ State ____

Spouse's SS# ____________________ Drivers License # ____________ State ____

EMERGENCY INFORMATION

In Case of Emergency, Please Notify ______________________________ Phone __________

REFERRAL INFORMATION

Whom may we thank for referring you? ❑Friend ____________________ ❑Yellow Pages ❑Web Page

INSURANCE INFORMATION

Name of Policy Holder ____

Insurance Company ____

Phone Number ________________ Policy # ______________ Group #____________

RECORDS RELEASE: I hereby authorize **Dr. Richard S. McDonald** to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care.

Signature ______________________________________

ASSIGNMENT OF BENEFITS: I also authorize and request your company to pay **Dr. Richard S. McDonald** the amount due me in my pending claim for dental treatment or services rendered to me.

Signature ______________________________________