NEW PATIENT INFORMATION FORM

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MALE ☐ FEMALE ☐ MINOR
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ **TELEPHONE** _____
MONTH DAY YEAR HOME WORK CELL

SOCIAL SECURITY # _____ **E-MAIL** _____

NAME OF EMPLOYER _____ **ADDRESS** _____

IF FULL-TIME STUDENT, SCHOOL NAME _____ **GRADE** _____

PERSON RESPONSIBLE FOR ACCOUNT – **PLEASE CHECK ONE** ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION FOR THE POLICY HOLDER
If no insurance, please complete for Responsible Person

Do you have Secondary Insurance? ☐ YES ☐ NO

LAST FIRST M

BIRTHDATE (M/D/Y) RELATIONSHIP TO PATIENT

STREET CITY STATE ZIP

EMPLOYER DENTAL INS. CO.

HOME PHONE CELL PHONE WORK PHONE

SSN SUBSCRIBER # GROUP #

EMERGENCY CONTACT INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

WERE YOU REFERRED?

Name: _____

AUTHORIZATION

▪▪By signing below, I authorize payment directly to Lasting Impressions Dental Care LLC of the group insurance benefits otherwise payable to me.
▪▪I hereby authorize Lasting Impressions Dental Care LLC to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care.
▪▪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 by any method, including electronic transfer.
▪▪IF MY ACCOUNT BECOMES DELINQUENT, IT MAY BE FORWARDED TO AN OUTSIDE COLLECTION AGENCY WITHOUT NOTICE. If this happens, I will be responsible for all costs of collection, included but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I understand that I am responsible for all costs of dental treatment.

X _____
STATE DRIVER'S LICENSE # **PATIENT OR RESPONSIBLE PARTY**