



QDW#: _____

Patient Information			
Patient Name: LAST:	_____	FIRST:	_____ M.I. _____ School: _____
Date of Birth:	____/____/____	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____
Last Dental Visit:	____/____/____	Reason For Visit:	_____ Last X-rays Taken: ____/____/____
Last Dentist's Name:	_____	City:	_____ Phone (____) _____ - _____
Reason for today's visit/chief dental complaint: _____			

Responsible Party Information			
Name: LAST:	_____	FIRST:	_____ M.I.: _____ Relationship: _____
Date of Birth:	____/____/____	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female Social Security Number: _____
Address Street:	_____		Apartment #: _____
City:	_____	State:	_____ Zip Code: _____
Home Phone No.:	(____) _____	Mom's Cell:	(____) _____ Dad's Cell (____) _____
Mom's Work No.:	(____) _____	Dad's Work No.:	(____) _____ E-mail: _____
Emergency contact other than family member: Name _____ Phone: (____) _____			
Who may we thank for referring you to our office: <input type="checkbox"/> Internet <input type="checkbox"/> Flier <input type="checkbox"/> Passing By <input type="checkbox"/> Mailer			
<input type="checkbox"/> Patient: _____ <input type="checkbox"/> Doctor: _____ <input type="checkbox"/> Other: _____			

Please List All Members Of Your Immediate Family			
Family Member's Full Name	Now A Patient In This Office?	Date of Birth	Relationship to Patient
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Primary Dental Insurance Information	Secondary Dental Insurance Information
Insured's Name: _____	Insured's Name: _____
Insured's Date of Birth: ____/____/____	Insured's Date of Birth: ____/____/____
Insured's Social Security Number: _____	Insured's Social Security Number: _____
Insured's Employer: _____	Insured's Employer: _____
Insured's Employer Phone No.: (____) _____	Insured's Employer Phone No.: (____) _____
Insurance Company Name: _____	Insurance Company Name: _____
Insurance Company Phone No.: (____) _____	Insurance Company Phone No.: (____) _____
Insurance Group No.: _____ Local: _____	Insurance Group No.: _____ Local: _____

Our office is collecting ethnic and racial information in order to develop systems and staff to provide the best quality of care to all of our patients. To do this we ask that you make the most appropriate selection regarding the race and ethnicity from the choices listed below. This information is voluntary and confidential.

Ethnicity: Hispanic Non-Hispanic White Black Native American/Eskimo/Aleut Asian/Pacific Islander Other: _____ Unknown

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 charges regardless of insurance coverage. I hereby authorize the Dental Office to administer such medications including the use of local anesthetic and to 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 true and correct to the best of my knowledge. I hereby authorize the Dental Office to release my dental/medical information and other information about my dental treatment to third party payors and other health professionals.

Signature: _____ (If a minor, parent or legal guardian) Driver's Lic #: _____ State: _____ Date: ____/____/____