CONFIDENTIAL PATIENT INFORMATION

PATIENTS' NAME			Last	First	Middle Initial		DATE OF BIRTH (MM/DD/YY)			GENDER
										F □
PREFERRED NAME										M □
							HOME PHONE #			
	□ Adult	□ Child	□ Child under Guardianship							
Name of Guardian (if applicable)							CELL PHONE #			
PATIENT ADDRESS										
							WORK PHONE #			
EMAIL ADDRESS										
By which way do you prefer to communicate with us?						(Check more than one choice if necessary)				
HOME #	□	CELL #	□	WORK #	□	EMAIL	□			
MARITAL STATUS			EMPLOYER				OCCUPATION			
EMERGENCY CONTACT (Other then your family home)										
NAME:			RELATIONSHIP:			WORK #		HOME #		
HOW DID YOU HEAR ABOUT US? Please circle referral										
	FRIENDS/FAMILY (Please name so we can thank them: _____)									
	WEBSITE		GOOGLE		FLYER		DRIVE BY		FACEBOOK	
INSURANCE COVERAGE	□Yes		□No		If yes, please give insurance card to office					

I authorize Trinity Family Dental to submit any necessary pre-determinations inquiring further information about my dental benefits for recommended treatments. Yes ____ No_____

GENERAL RELEASE

I, the undersigned, cerify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answer to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers main specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures as my be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the responsibility for payment of the dental service for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **2 business days** notification to avoid any minimum charges.