

ADULT PATIENT INFORMATION

Name: _____ () married () single () male () female
Last First Middle Initial

What name would you like to be called in this office? _____

Whom may we thank for referring you?

Name _____ Family Member / phone book / doctor / other

FAMILY INFORMATION

	SELF	SPOUSE
Name:	Last First Middle	Last First Middle
Address:	Street City State Zip	Street City State Zip
Telephone:	Home # Work # extension	Home # Work # extension
Birthdate/SS#	Month/day/year Social Security #	Month/day/year Social Security#
E-mail Address		
Employer:	Employer Occupation	Employer Occupation
Dental Ins:	Dental Insurance Co Group #	Dental Insurance Group #
Address:		

Person responsible for account: Check One: () Self () Spouse

Two people to contact outside of immediate family in case of emergency:

Name: _____ Telephone # _____

Address: _____
Street City State Zip

Name: _____ Telephone # _____

Address: _____
Street City State Zip

Authorization: I hereby authorize payment directly to William H. Claypoole, DMD of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Arrangements must be established prior to treatment. Where appropriate and necessary, credit bureau reports will be obtained. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of by knowledge.

Signature of Responsible Party: _____ Date: _____