

PATIENT INFORMATION

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

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

Address: _____ City: _____ State: _____ Zip: _____
Street/PO Box/Apt #

Phone: _____ Date of Birth _____ Social Security # _____

School: _____ Grade _____

Whom may we thank for referring you?

Name _____ Family Member / phone book / doctor / other

FAMILY INFORMATION

	FATHER			MOTHER		
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: () Father () Mother () Guardian

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 my knowledge.

Signature of Responsible Party: _____ Date: _____