436 Court St., Reno, NV 89501

Patient Information

Name_____
LAST FIRST PREFERRED NAME

Address_____
STREET

_____
CITY STATE ZIP

Employer _____ Driver's License_____

Date of Birth_____ Height _____Weight_____

Phone: Home _____ Social Security # _____

Cell_____ Please Circle:

Work_____ Sex: Female/Male Status: Married/Single/Divorced/Widow

Email Address: _____

Emergency: Name_____ Phone_____

Who may we thank for referring you to us? _____

Dental Insurance:

Primary Dental Carrier

Subscriber Name _____ Social Security #_____DOB_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security #_____DOB_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to Patient_____

Insurance Authorization Statement

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 costs and dental treatment. 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 of this page and the medical history are correct to the best of my knowledge.

Signature_____ Date_____