347 Marsh Ave., Reno, NV 89509

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_____________________