MAGNOLIA
Family Dental

PATIENT INFORMATION

Date _____

Name _____ ❑ Married ❑ Single ❑ Minor ❑ Male ❑ Female
Last First M

Address _____
Street Apt # City State Zip

Birth Date _____ Age _____ SS# _____

Telephone _____ Cell _____ Email _____

Place of Employment _____ Phone _____

If Full-time Student, School Name _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative

❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other _____

Name of person or office referring you to our practice _____

INSURANCE INFORMATION

Primary

Name of Insured _____ Is insured a patient? ❑ Yes ❑ No

Insured's Birth Date _____ SS# _____ Group # _____

Insured's Address _____
Street Apt # City State Zip

Insured's Employer's Name _____

Address _____
Street City State Zip

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name and Address _____

AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

_____ Date _____
Patient's or Guardian's Signature