

PATIENT INFORMATION

NAME _____ DATE _____
Last First MI

ADDRESS _____
Street Apt City State Zip

PHONE Home _____ Work _____ Marital Status _____

DATE OF BIRTH _____ S.S.# _____

EMPLOYER _____ SPOUSE'S NAME _____

Has any member of your family ever been treated in our office? _____ Yes _____ No

Whom may we thank for referring you to our office? _____

Person financially responsible for this account _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ ADDRESS _____

PHONE Home _____ Work _____ EMPLOYER _____

INS. COMPANY NAME _____ PHONE _____

ADDRESS _____ GROUP # _____

EMERGENCY INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY _____

PHONE Home _____ Work _____

AUTHORIZATION

I hereby authorize release of any information relating to dental treatment to my dental insurance company for processing of dental claims.

I hereby give Dr. Stephen Miller the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

SIGNATURE _____