Date: ____________________

NEW PATIENT / UPDATE INFORMATION

Name ____________________ Male/Female __________ Marital Status __________

Address ____________________ City ____________________ State ________ Zip __________

Social Security # ____________________ Date of Birth ____________________ Age __________

Home # ( ) ____________________ Business # ( ) ____________________ Ext. __________

Mobile # ( ) ____________________ E-Mail ______________________________

Employer's Name ______________________________ Position ____________________

Name of Spouse ____________________ Social Security # ____________________

Address (If different from above) ______________________________ Spouse DOB __________

Spouse Employed by ____

Spouse Business Phone # ( ) ____________________ Ext. ______ Spouse Position ______________

Spouse Mobile # ( ) ____________________ E-Mail ______________________________

Children Names & Ages ____

How did you hear about us? ____

Name, Address & Phone # of **local** emergency contact. ______________________________

____

Chief Dental Concern ____

PERMIT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental and/or oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures.

Patient's (Parent's Signature) ______________________________ Date: ____________________

DENTAL INSURANCE INFORMATION

Name of Company or Companies ____

____

(We will need a photocopy of card (s):).

I understand that as a service (to me) Drs. Steiner, Pappert & Linger will assist me in processing my insurance claims. However, I am responsible for all fees in their entirety at time treatment is performed.

Patient's (Parent's Signature) ______________________________ Date: ____________________

I understand my complete medical history is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Signature of Patient or Guardian ______ Date ______

Signature of Patient or Guardian ______ Date ______

Signature of Patient or Guardian ______ Date ______

Signature of Patient or Guardian ______ Date ______

Signature of Patient or Guardian ______ Date ______

Signature of Patient or Guardian ______ Date ______

Note: New Patient Information Sheet is requested every two years. Updated signatures are requested a minimum of every 6 months. Your assistance is appreciated.