Patient Information *(Please Print)*

Name_____Date_____
First middle last

Date of Birth_____SS#_____

Name you prefer to be addressed by_____

Address_____City_____State_____ Zip_____

Home phone#_____Work#_____Cell#_____

Do you preferred to be contacted (daytime)? ☐ home ☐ cell ☐ work

Email address_____

Employer_____Occupation_____

Spouse's or Parent's name_____Daytime phone #_____

Person to contact in case of emergency_____

Relationship to patient_____Daytime Phone #_____

Is anyone in your family or close friend a patient here? ☐ Name_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____Home Phone #_____

Address_____City_____State_____Zip_____

For your convenience we offer several methods of payment

☐ Cash ☐ Personal check ☐ Credit Card ☐ Care Credit Financing

Payment in full is expected at each appointment.

Dental Insurance Information

Name of insured_____Relationship to patient_____

Date of Birth_____SS#_____Home #_____

Name of Employer_____Work Phone #_____

Insurance Company_____Group #_____

AUTHORIZATION

I hereby authorize payment directly to Morgan Family Dentistry, PLLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of 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 on this page and the medical history are correct to the best of my knowledge.

Signature of Responsible Party X _____