



Patient Information

Name: _____

Last MARRIED SINGLE MINOR MALE FEMALE

Address: _____

Street Apt# City State Zip

Birthdate: ___/___/___ ODL/ID#: _____ Email: _____

MM DD YYYY

Telephone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____

Home#

Cell#

Work#

Employer: _____ SS#: _____

Person Responsible For account:

PATIENT GUARDIAN FATHER MOTHER

Insurance Information

Primary Insured

Secondary Insured

Last First MI

Last First MI

Street City State Zip

Street City State Zip

() () ()
Home # Work # Fax #

() () ()
Home # Work # Fax #

Email

Email

/ /
Birthdate MM/DD/YYYY Relationship to patient

/ /
Birthdate MM/DD/YYYY Relationship to patient

Employer Dental Insurance Company

Employer Dental Insurance Company

SS# Subscriber# Group #

SS# Subscriber# Group #

Emergency Contact

Name _____
Address _____
City/State/Zip _____
Phone # _____

Have any of your family members been to our office? Yes / No (circle one)
If yes, Who? _____
How did you hear about us? _____

Authorization

I hereby authorize payment directly to Camas Periodontics of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Riverplace Periodontics to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature of Patient, Parent, or Gaurdian _____ Date: _____