

**PATIENT**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

May we contact you at work?  Yes  No      What is the best time of day to reach you? \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**RESPONSIBLE PARTY** (required for patients under 18 or if the responsible party is someone other than the patient)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**DENTAL INSURANCE POLICY HOLDER INFORMATION**

Name of Policy Holder: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Patient Relationship to Policy Holder:  Self  Spouse  Child  Other

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**METHOD OF PAYMENT**

Responsible party currently has an account with this office       Yes  No

Payment in full at each appointment by cash or personal check       Yes  No

Payment in full at each appointment by credit card       Yes  No

I wish to discuss the Smile Columbia Third Party Financing       Yes  No

**AUTHORIZATION AND CONSENT**

I understand that I am responsible for all costs of dental treatment. I hereby authorize Hahn and Hahn Dentistry Partnership DBA Smile Columbia 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 dental medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X \_\_\_\_\_ Date: \_\_\_\_\_  Patient  Responsible Party