## PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

The information provided is important to your dental health.

Patient name:			□ <b>M</b> □ <b>F</b> DOB	Goes by:
Father/Guardian name:	First	Last	DOB:	-
	First	Last		
Mother/Guardian name: _	First	Last	DOB:	
Address:		City		
Driver licence #:	Street # City		State SSN:	zip code
Home Phone#:	Cell:		work:	
Mother's Email:			Father's Email:	
		♦ FINANCIAL R	ESPONSIBILITY <b>◊</b>	
Subscriber Name:			DOB:	
Subscriber Employer:			SSN:	
INS Carrier:				
INS Phone#:		MEM #	GRP #	
Is patient Cover by additi Subscriber Name:			DOB:	
Subscriber Employer:			SSN:	
INS Carrier:				
INS Phone#:		MEM #	GRP #	
		PRIVACY S	STATEMENT	
This office will not releas	se any information	medical or dental office	t to parents, legal guardians, your inses, except by court order. & Ashley Featherston DDS	urance carrier, or to other referre
	NOWLEDGE	MENT OF RECEIP	T NOTICE OF PRIVACY P	RACTICES
			Date of Birth: vith our Notice of Privacy Practices. To o describes certain rights you have ab	
Signature of Pation	ent, Parent, Guard	ian or Personal Representati	ive	Date

Date

Please print name of Patient, Parent, Guardian or Personal Representative