## PATIENT INFORMATION

Name: ____________________

Address: ____________________

City: ____________________ State: ________ Zip: ____________

Phone: ______-________-_________ Email: ____________________

Birthdate: _____/_____/__________ SSN: ________-______-__________

Patient's (or Parent/Guardian's) Employer: ____________________

Spouse Name, if Applicable: ____________________

Parent/Guardian's Name if Minor: ____________________

Previous Dentist (Name & Location): ____________________

Last Dental Visit: ____________________

Whom May We Thank for Referring You: ____________________

Emergency Contact: ____________________

Relationship: ____________________ Phone: ______-________-_________

## PERSON RESPONSIBLE FOR ACCOUNT (if different than above)

Name: ____________________

Relationship: ____________________ Phone: ______-________-_________

Address: ____________________

City: ____________________ State: ________ Zip: ____________

Birthdate: _____/_____/__________ SSN: ________-______-__________

## AUTHORIZATION AND RELEASE

I authorize Galena Family Dental, P.C. to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Galena Family Dental, P.C. insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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Signature of Patient (or Parent/Guardian if Minor)