RENEW DENTAL

Name of Patient _____ **Birthdate** _____

Social Security No. _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Email Address _____

Mobile Phone _____ Work Phone _____ Pager _____

Employer _____ City _____ Occupation _____

Who referred you to this office? _____

Name of Parent/Partner/Spouse/Guardian _____ **Birthdate** _____
(circle one)

Social Security No. _____

Street Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Ext _____

Employer _____ City _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____
(other than spouse)

INSURANCE INFORMATION

Employee Name _____

INS CO Name _____

INS CO Address _____

INS CO City, ST Zip _____

Insurance Phone _____

Group/Policy # _____

Employee SSN _____

Birthdate _____

INSURANCE INFORMATION

Employee Name _____

INS CO Name _____

INS CO Address _____

INS CO City, ST Zip _____

Insurance Phone _____

Group/Policy # _____

Employee SSN _____

Birthdate _____

Patient Acknowledgments:

- I understand that I am responsible for any uninsured balance.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read, and I agree to the above acknowledgments:

Signature of patient _____ Date _____
(parent or guardian, if patient is a minor)