PATIENT INFORMATION

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Driver's License # _____

Male ❑ Female ❑ DOB: _____ SS#: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Address _____

Email Address: _____ Marital Status: M ❑ S ❑ D ❑ W ❑ Under 18 ❑

Employer/Occupation _____

Work Phone: ( ) _____ Cell Phone:( )_____

Spouse First Name _____ Last Name _____ Middle Initial _____

Spouse Employer/Occupation _____

Work Phone: ( ) _____ Cell Phone:( )_____

Primary Dental Insurance _____

Secondary Dental Insurance _____

PARENT INFORMATION - complete if patient is a minor or dependent student

Father's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City/State _____ Zip _____

Home Phone: ( ) _____ Work Phone: ( )_____ Cell Phone: ( ) _____

Occupation _____

Employer's Name/Address _____

Mother's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City/State _____ Zip _____

Home Phone: ( ) _____ Work Phone: ( )_____ Cell Phone: ( ) _____

Occupation _____

Employer's Name/Address _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.
I authorize my dentist and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I hereby authorize my insurance company to pay directly to Joseph Ferguson, DDS any benefits for dental care rendered.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) **Date**

FEES & PAYMENTS
An estimate of the charge for any procedure you may require will be given to you. If you have any dental insurance we will be glad to submit your claim. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. All procedures may not be a covered benefit. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) **Date**

CHANGES

_____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date _____ Initial/Date