Welcome

PATIENT INFORMATION

Patient Name: ____ Date: ___/__/____

Soc. Sec. #:_____-____-_______ Birth date: ____/___/______ DL#:________________________

Home Address: ____

City: __________________________________ State: _________ Zip Code: ______________

Home Phone: (______)_________-____________ Cell Phone: (______)_______-_______________

Emergency Contact: ______________________ Phone: _______________________________

Email Address: ____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Are you an active user of any of the following? Please circle all that apply:

Facebook Yelp Google/Gmail Twitter Angie's List

What is your preferred method of communication? Please circle all that apply:

Text Email Home Phone Cell Phone

Who should we thank for referring you?

☐ Another Patient (Name): ___________________ ☐ Yelp ☐ Angie's List
☐ Place of employment ☐ Facebook ☐ Google ☐ Magazine
☐ Dental Office ☐ Our Website ☐ Radio ☐ Event/ Charity
☐ Post Card ☐ Insurance ☐ Other ☐ Location

Please read carefully below

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE LINTON FAMILY DENTISTS TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND LINTON FAMILLY DENTISTS, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO LINTON FAMILLY DENTISTS AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

Patient Signature: ______________________________ Date: ____/____/_____