MID BAY DENTAL
COMPREHENSIVE DENTAL WELLNESS

Date:_____ Patient's Name: _____

○ Male ○ Female Date of Birth: _____

Address: _____ Home Number: _____

City: _____ State: ____ Zip Code: _____ Work Number: _____

○ Minor ○ Married ○ Single Cell Number: _____

Social Security Number: _____ Email: _____

Place of Employment: _____ Which Confirmation Methods do you Prefer?

☐ Phone ☐ Text ☐ Email

Who may we thank for referring you to our office? _____

Primary Dental Insurance: _____ Subscriber #: _____ Group #: _____

Secondary Dental Insurance: _____ Subscriber #: _____ Group #: _____

Responsible Person For Account

☐ Parent/Guardian ☐ Spouse ☐ Same as Patient

Name: _____ DOB: _____

Address: _____City: _____ State: _____ Zip:_____

Home #: _____ Work #: _____Cell #: _____ SS #: _____

Employer: _____

Primary Dental Insurance: _____ Insurance Phone #: _____

Subscriber/Member ID: _____ Group #: _____

Emergency Contact Name: _____ Phone #: _____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. Patient portion is due in full at the time of service. The information provided on all forms are correct to the best of my knowledge. I grant the right to the Dental Office to release dental/medical information including diagnostic records and photographs to third party payors or other health care professionals in consultation or as educational material.
I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational or promotional purposes.

Name of Patient,
Parent or Guardian: _____ Signature: _____