FAMILY DENTISTRY EVERY smile + ORTHODONTICS

## Patient Information

Patient Name_______________________________________ Preferred Name ___________________

Birth Date _________________Age_______ Soc. Sec #____________________________________

Local Address ________________________________________________ Lot #_________________

City_____________________________________ ST ___________ Zip _______________________

Home Tel. (____) ______________ Cell (____) _______________ Bus. Tel. (____) ______________

Employer __________________________**Email**_____________________________________

How would you like us to contact you?  Email  Text  Phone Call  Other: ___________________

Emergency Contact Name and Daytime Phone Number_______________________________________

**Who can we thank for referring you?** ____________________________________________________

## Responsible Party Information (if different than above)

Name_______________________________________________ Relationship to patient_____________

Social Security__________________ Birth date____________ Marital Status___________________

Address ________________________________________________________________________

Home (____) ________________ Cell (____) ______________ Daytime Tel. (____) _____________

Employer______________________________________________ Bus. Tel. (____) _________________

## Insurance Information

Insured's Name__________________________________________ Birth date ___________________

Soc. Sec. #__________________________ ID # ____________________ Group #_______________

Employer______________________________ Insurance Company_____________________________

Insurance Phone (____) ______________ Address for Claims___________________________________

**Consent:**

- I authorize Dr. Dennis Lloyd and his associates to take x-rays, photographs, or any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of my dental needs. I also authorize Dr. Lloyd or his associates to prescribe any and all forms of medications, and perform any therapy that may be indicated and agreed upon.
- I authorize the release of any information, including the diagnosis and the record of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of billing, and I authorize the payment of benefits to which I am entitled, directly to the dentist.

Patient___________________________________________________Date______________________

Parent or Responsible Party_________________________________Relationship to Patient______________