PATIENT INFORMATION

FIRST NAME: _____ **LAST NAME**: _____

ADDRESS: _____ **APT**: ____ **CITY, STATE, ZIP**: _____

HOME PHONE: _____ **WORK PHONE**: _____

CELL PHONE: _____ **E-MAIL**: _____

BIRTH DATE: _____ **SOCIAL SECURITY #:** _____ **DL#:** _____ **EXP**: _____

EMPLOYER: _____ **DENTAL INSURANCE**: YES NO

SEX: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED SEPERATED WIDOWED

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME: _____ **RELATIONSHIP TO PATIENT**: _____

RESPONSIBLE PARTY DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

RESPONSIBLE PARTY ADDRESS: _____

IF STUDENT: SCHOOL NAME: _____ **LOCATION**: _____

SEX: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED SEPERATED WIDOWED

HOW DID YOU HEAR ABOUT OUR OFFICE? _____ **(INCENTIVES FOR REFERRALS!!)**

WHAT WOULD YOU LIKE TO ACCOMPLISH WITH TODAY'S VISIT? _____

_____

_____.

WHAT DID YOU LIKE OR DISLIKE ABOUT YOUR LAST DENTIST AND DENTAL OFFICE? _____

_____

_____

_____.

IS THERE ANYTHING THAT CONCERNS YOU ABOUT THE APPEARANCE OF YOUR TEETH? _____

_____

_____

THE UNDERSIGNED HEREBY AUTHORIZES DR. BAXLEY TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I FURTHER AGREE TO ALLOW DR. BAXLEY TO USE THE AFOREMENTIONED FOR ANY ACADEMIC REASON AND UNDERSTAND THAT MY IDENTITY WILL BE KEPT PRIVATE AT ALL TIMES. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES AND THAT THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

_____ _____

PATIENT SIGNATURE ***DATE SIGNED***