Mason Dental

Patient Information

Patient

Name _____
Address_____
City_____ **Zip** _____
Phone _____
E-mail _____
Social Security _____
Age _____**Birthdate**_____

Responsible Party

(If same as above, please skip)
Relationship to Patient _____
Name _____
Address_____
City_____ **Zip** _____
Phone _____
E-mail _____
Social Security _____
Age _____**Birthdate**_____

Emergency Contact

Name _____
Phone_____
Physician_____
Phone _____

Getting to Know You

Do you have family members who need dental care? If so, please list their name & relationship.
1._____**2.**_____
3._____**4.**_____

How did you hear about our office? (check one)

- ☐ **Facebook/Instagram**
- ☐ **Google**
- ☐ **Family/Friends**
- ☐ **Flyer**
- ☐ **Office Sign**
- ☐ **Insurance**
- ☐ **Radio**
- ☐ **Other**_____

Scan Here To Follow Us!

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or pald by my insurance for whatever reason.
1. By signing below, tauthorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
1. authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that i am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
1. I understand that this dental practice is owned and operated by and independent dentist, I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party **Date**