Patient's Name _____
Last Name First Name Middle Initial

Address _____ City _____St_____ Zip _____

Home Phone (_____) -_____ Cell Phone (_____) -_____ Work Phone (_____)-_____

Date of Birth_____ Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer_____Occupation _____

Social Sec #_____ E-Mail Address: _____

Name of Parent /Partner/ Spouse / Guardian _____
Last Name First Name Middle Initial

Address (if different) _____ City_____ St_____ Zip_____

Birthdate_____ Social Security #_____

Home Phone (____) -_____ Cell Phone (____) -_____Work Phone (____) -_____

Employer _____City _____ Occupation _____

Who referred you to this office _____

In case of emergency, whom shall we notify?

Name_____Relationship _____ Phone _____

PRIMARY DENTAL INSURANCE INFORMATION	**SECONDARY DENTAL INSURANCE INFORMATION**
EMPLOYEE NAME_____	EMPLOYEE NAME _____
BIRTHDATE _____	BIRTHDATE _____
EMPLOYER NAME_____	EMPLOYER NAME_____
INS CO NAME _____	INS CO NAME _____
GROUP/POLICY # _____	GROUP/POLICY #_____
SUBSCRIBER ID/SSN# _____	SUBSCRIBER ID/SSN#_____

Patient Acknowledgments:

- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I consent to the publication of my photos released to Dr. Boggess and Maggiore.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor