PATIENT INFORMATION

Thank you for choosing us as your dental care provider. We look forward to caring for you!

Patient Information:

Patient Name (First Middle Initial Last): _____ DOB: ____/_____/____

SS#: _____/_____/_____ Marital Status: *Single Married Divorced Widowed*

Address: _____

City _____ State _____ Zip code _____ Sex: Male Female

Home phone: (____)_____Work phone: (____)_____Cell phone: (____)_____

Email Address_____

Opt-In Disclaimer: Summercrest Dental sends out patient communications (i.e. appt. reminders) via email, cell, and landline info provided. We do not share your information with other parties. If you do not wish to receive our communications, you may opt-out at jennifer@summercrestdental.com or call us at 913-491-4516.

Responsible Party (Complete if responsible party is someone other than the patient):

Name (First Middle Initial Last):_____ Relationship: _____

SS#: _____/_____/_____ DOB: ____/_____/____ Employer_____

Address: _____

City _____ State _____ Zip code _____ Sex: Male Female

Emergency Contact Information:

Name: _____Phone: _____

PRIMARY INSURANCE

Ins. Co: _____

Group #: _____

ID#_____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#:_____/_____/_____DOB: _____/____/_____

Employer: _____

SECONDARY INSURANCE

Ins. Co: _____

Group #: _____

ID#_____

Phone #: _____

Name of Insured: _____

Relationship to patient: _____

SS#: _____ /_____/_____ DOB: _____/_____/_____

Employer: _____

I hereby authorize the doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon diagnosis, I authorize the doctor to perform the recommended treatment agreed upon by me and to employ assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete narration of any possible risks of complications.

X

_____

Patient Signature (or guardian)