Patient Information

Name: _____
First Middle Last

Address:_____
Street City State Zip Code

Contact No: _____
Home Work Cell

Email: _____

Date of Birth_____ **Sex : M F Martial Status M S D W Minor**

Social Security No:_____ **Drivers License No:** _____

Employer Name and Address _____

If Full Time Student, School Name _____

Insurance Information

Primary Insured: _____
Date of birth _____ **SS# or Ins. ID#** _____
Relationship to patient _____
Insurance Co: _____ **Employer** _____
Group # _____

Secondary Insured:_____
Date of birth _____ **SS# or Ins. ID#** _____
Relationship to patient _____
Insurance Co: _____ **Employer** _____
Group # _____

If Minor Parent or Guardian Information

Father Name: _____
First Middle Last

Address _____ **Phone:**_____

Mother Name:_____
First Middle Last

Address_____**Phone:** _____

Emergency Contact: _____
Name Phone

Who may we thank for the referral _____

Authorization:

I herby authorize Thomas M Green DDS, Inc., to administer such treatment and perform such diagnostic, photographic and therapeutic procedures as many be necessary for proper dental care. The information on this page and the dental and medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and or health professional s.

X_____ **Date**_____
Patient or Responsible Party