SAGE DENTAL NEW PATIENT INFORMATION

PATIENT INFORMATION

First Name: _________________ Last Name ___________________ Middle Initial _____ Preferred Name ____________

Home Address: ___________________________________City_________________State_______Zip___________

Home Phone: (_____) _____________Work: (_____) _____________ext. ________ Cell: (_____) _____________

Receive Text: yes [ ] no [ ] Which is the best way to contact you: Cell [ ] Text [ ] Email [ ] Home Phone [ ]

Male [ ] Female [ ] Marital Status: Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]

Birth date: ______________ Age: _______ S.S. #: ______________________

E-mail Address: __________________________________ [ ] I would like correspondences via e-mail

Employer: ___________________ Preferred Pharmacy: _____________ Referred by: _______________________

Previous Dentist: _____________________ Emergency Contact: _________________Phone: (____) _____________

RESPONSIBLE FOR ACCOUNT (If other than patient)

First Name: _________________ Last Name ___________________ Middle Initial _____

Billing Address: __________________________________City______________State____Zip________

Home Phone: (____) _______________ Work: (____) ______________ Cell: (_____) _____________

Birth date: _____________ S.S. #: _____________________ Relation to Patient: ____________________

Employer: __________________________How long there? _______ Occupation:___________________

DENTAL INSURANCE INFORMATION

Primary Insurance

Insured's Name: __________________________ Relation to patient: Self [ ] Spouse [ ] Child [ ] Other [ ]

Insured's S.S. #: : __________________ Insured's Birth date: ______________ Employer: __________________

Insurance Co. Name: ______________________________________Phone: (____) _________________

Group/Policy #: __________________________________ ID #__________________________________

Secondary Insurance

Insured's Name: ___________________________ Relation to patient: Self [ ] Spouse [ ] Child [ ] Other [ ]

Insured's S.S. #: : __________________ Insured's Birth date: ____________ Employer: __________________

Insurance Co. Name: ______________________________________Phone: (____) _________________

Group/Policy #: __________________________________ ID #__________________________________

Please help us better understand your dental health needs and goals by answering the following questions.

Have you had a full mouth set of x-rays within the last 3 years? [ ] **Yes** [ ] **No** Date of last Dental Visit ____________

AUTHORIZATION AND CONSENT

General Consent to Treatment: [ ] I agree and consent to a dental examination by Dr. Siemen and/or Dr. Gillette. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information [ ] I authorize Dr. Siemen and/or Dr. Gillette to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits [ ] I authorize and request my insurance company to pay my benefits directly to Dr. Mooney, Dr. Siemen and/or Dr. Gillette.

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

[ ] I hereby acknowledge that I have read a copy of this practice's Notice of Privacy Practices.

[ ] I understand that I may ask any questions I might have regarding this notice or request a copy.

X ____ Date ________________________

Signature of patient, parent or guardian