

## Patient Information

Name: \_\_\_\_\_  
Last First MI  
 MARRIED  SINGLE  MINOR  MALE  FEMALE

Address: \_\_\_\_\_  
Street Apt# City State Zip

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_  
MM DD YYYY

Telephone: (\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_ - (\_\_\_\_) \_\_\_\_\_  
Home# Work# Fax#

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Person Responsible For account:  
 PATIENT  GUARDIAN  FATHER  MOTHER

## Insurance Information

### Primary Insured

\_\_\_\_\_  
Last First MI  
\_\_\_\_\_  
Street City State Zip  
\_\_\_\_\_  
( ) ( ) ( )  
Home # Work # Fax #  
\_\_\_\_\_  
Email  
\_\_\_\_\_  
/ / /  
Birthdate MM/DD/YYYY Relationship to patient  
\_\_\_\_\_  
Employer Dental Insurance Company  
\_\_\_\_\_  
SS# Subscriber# Group #

### Secondary Insured

\_\_\_\_\_  
Last First MI  
\_\_\_\_\_  
Street City State Zip  
\_\_\_\_\_  
( ) ( ) ( )  
Home # Work # Fax #  
\_\_\_\_\_  
Email  
\_\_\_\_\_  
/ / /  
Birthdate MM/DD/YYYY Relationship to patient  
\_\_\_\_\_  
Employer Dental Insurance Company  
\_\_\_\_\_  
SS# Subscriber# Group #

### Emergency Contact

Name \_\_\_\_\_ Have any of your family members been to our office?  Yes  No  
Address \_\_\_\_\_ If yes, Who? \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ How did you hear about us? \_\_\_\_\_  
Phone # \_\_\_\_\_

### Authorization

I hereby authorize payment directly to Murrayhill Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Murrayhill Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/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 other health professionals

Signature of Patient, Parent, or Gaurdian \_\_\_\_\_ Date: \_\_\_\_\_