Starr General Dentistry

Patient Information

Patient Name: ______________________________________(____________________) Date:______________
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _______________

Social Security #: ________________________________ Birth Date:______________________________

Phone (Home): _______________________ (Cell): ______________________ (Work):_________________

Email: ____ Driver License #:________________________

Address: ____
Street Apartment # City State Zip Code

Emergency Contact Name and Phone Number:____

Responsible Party Information

Name: ____ Relation to Patient: ____________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ________________________________ Birth Date: _____________________________

Phone (Home): _____________________ (Cell): ____________________ (Work):_____________________

Address: ____
Street Apartment # City State Zip Code

Employer Name: _________________________________ Current Patient of Starr Dentistry? ☐Yes ☐No

Address: ____
Street City State Zip Code

Preferred Method of Contact and Appointment Reminders

check all that apply: ☐ Cell ☐ Home ☐ Text ☐ Email

Dental Insurance Information

Primary

Subscriber: ____ Is the insured an existing patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID # or SSN: _____________________ Group #:_______________

Insurance Carrier Name: ____

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Secondary

Subscriber: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID # or SSN: _____________________ Group #:_______________

Insurance Carrier Name: ____

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Consent for Services

The best dental health services are based on a friendly, mutual understanding between provider and patient. You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Statement of consent: I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment I have requested and authorized.

____ Date: ____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian