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