

Jason T. Bolding, DDS

Comprehensive Family Dentistry

Chart Number: _____

Date: _____

PATIENT'S INFORMATION (please completely fill out front and back)

Patient's Full Name: _____ Name you like to be called by: _____
First, Middle, Last

Patient's Address: _____ Soc. Sec. #: _____
Street, Apt. No. City, State, Zip

Home Phone (____) _____ Date of Birth: ____/____/____ Marital Status Single Married Divorced Widowed

Cell Phone (____) _____ E-mail Address: _____ Driver's License #: _____

Place of Employment or School and Grade: _____ Phone: (____) _____

Person to contact in case of emergency: _____ Relationship _____ Phone: (____) _____

Whom May We Thank for Referring You? _____

PERSON RESPONSIBLE FOR ACCOUNT

Full Name: _____ Relation to Patient: _____
First, Middle, Last

Full Home Address: _____ Home Phone (____) _____
Street, Apt. No. City, State, Zip

Date of Birth: _____ Soc. Sec. #: _____ : Employer: _____

Work Phone: (____) _____ Employer's Address: _____

Name of Spouse Other Parent Secondary Responsible Person: _____
First, Middle, Last

Full Address: _____ Home Phone (____) _____

Date of Birth: _____ Soc. Sec. #: _____ : Work Phone (____) _____

Employer: _____ Employer's Address: _____

Are you interested in access to your account information on the web? _____

DENTAL INSURANCE INFORMATION

Insurance Company name and address: _____

Insurance Company Phone Number: (____) _____

Who is the insurance carried by? You Spouse Parent

Name of the person who carries the insurance: _____ Their date of birth: ____/____/____
First, Middle, Last

Insurance carrier's employer name and address: _____

Insurance Group Number _____ Insured person's Soc. Sec. #: _____

IF YOU HAVE ADDITIONAL INSURANCE PLEASE LET US KNOW

RELEASE

I authorize the doctor or other dentists or health care professionals to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.

I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.

I consent to the release credit reports and information regarding my credit history to the doctor(s).

I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Date: _____ Patient or Guardian's Signature _____