CLINT BRUYERE DDS

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.

PATIENT INFORMATION (CONFIDENTIAL)

Name : _____ Birthday: ____/____/____ SSN: ___-___-____

Address : _____ , City:_____ State: _____ Zip:_____

Phone #: (_____) -_____ - _____ Cell#: (_____) -_____ - _____ Work #: (_____) -_____ - _____ Ext:_____

E mail Address: _____ How did you hear about us? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Separated

Place of Employment : _____

If Patinet is Minor

Parents Name _____ Work # : (___) - ___ - ____ Ext: ____

Parents Employer: _____

Spouse's Details

His/Her Name: _____ Employer: _____

Person to Contact in Case of Emergency: _____ Phone#: (_____) -_____ - _____

RESPONSIBLE PARTY (RESPONSIBLE FOR THIS ACCOUNT)

His/Her Name: _____

Relationship : _____ Phone # : (___) - ___ - ____

Address : _____, City:_____, State:_____,Zip:_____

Driver's License # : _____ Birthdate : __/__/____ Cell # : (___) - ___ - ____

Is this person a patient in our office? ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check one. Payment made in full at each appointment.

☐ Cash ☐ Check Credit Cards: ☐ Visa ☐ MasterCard ☐ Discover ☐ CareCredit (upon qualifying)

DENTAL INSURANCE INFORMATION

Name of Insured : _____ Relationship : _____

Birthdate: __/__/____ SS # : ___-___-____

Name of Employer : _____ Work # : (___) - ___ - ____

Name of Insurance Co. : _____ Phone # : (___) - ___ - ____

AUTHORIZATION & RELEASE

☐ I certify that I have read and understood the above information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information on my medical history can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health care practitioners. **I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual dental bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

☐ I consent to the making of photos and x-rays before, during, and after treatment and the use of them by the dentist in scientific papers or demonstrations.

☐ I certify that I have read, or have been read to me, the contents of this form and do realize the risks and limitations involved.

Signature : _____ Date: _____/_____/_____