EXAMINATION CARD

Patient's Name: Last _____ First _____ Middle _____

Address _____

City _____ State _____ Zip _____

Address For Responsible Party If Different From Patient's Address

_____

Age ___ Birth Date _____ Sex ____ School _____ Grade _____

Home Telephone _____ Cell Telephone _____

Hobbies _____ Musical Instrument _____

Father _____ Birth Date _____

Occupation _____ Social Security # _____

Employed By _____ Work Telephone _____

Mother _____ Birth Date _____

Occupation _____ Social Security# _____

Employed By _____ Work Telephone _____

E-mail _____

Dentist _____ Physician _____

Referred By _____

Primary Insurance Information	Secondary Insurance Information
Policyholder Name _____	_____
ID/SS# _____	_____
Group # _____	_____
Insurance Name _____	_____
Insurance Address_____	_____
City, State and Zip code _____	_____

Please notify our office of any changes in the information you have provided.

Signature below authorizes this office to file claims and accept payment directly from the insurance company.

_____ _____

I understand that I am financially responsible for all charges incurred.
Signature of Responsible Party _____