Welcome to Bridge Dental Care

Date: ____/_____/_____

NAME_____ □ male □ female □ married □ single □ minor
Last first

ADDRESS_____
Street Apt# City Zip Code

BIRTH DATE ____ ____ _____ TELEPHONE # _____
Mo Day Year Home Work/Cell

PLACE OF EMPLOYMENT_____SS#_____

IF FULL TIME STUDENT, SCHOOL NAME_____GRADE_____

DENTAL INSURANCE CO._____SUBSCRIBER_____GROUP#_____

Has any member of your family ever been treated in our office? YES____ NO____

Whom may we thank for referring you to our office? _____

E-mail address:_____

FAMILY INFORMATION fill in both blocks for minor child/fill in appropriate block for adult

FATHER (OR HUSBAND)				MOTHER (OR WIFE)			
Last	first	M		Last	first	M	
Street	city	state	zip	Street	city	state	zip
Home phone	work phone			Home phone	work phone		
Birth date (mo/day/year)	SS#			Birth date (mo/day/year)	SS#		
Employer				Employer			
Dental insurance co.	Subscriber	Group		Dental insurance co.	Subscriber	Group	

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of immediate Family / Household

Please Check One

NAME_____ PATIENT____ FATHER OR HUSBAND____
ADDRESS_____
CITY/STATE/ZIP_____ GUARDIAN____ MOTHER OR WIFE_____
TELEPHONE_____

AUTHORIZATON

I hereby authorize payment directly to the Dental Office of the group Insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental / medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental / medical information about my dental treatment to third party payers and / or other health professionals.

✘ _____ ***Date:*** _____/_____/_____
Patient signature (parent or guardian)