



**Dr. R.E. O'Connor
Family Dentistry**

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Patient Information

Patient # _____
Date _____

Name _____ DOB _____ Sex M/F SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Marital Status (circle one) Minor Single Married Divorced Widowed Separated

Parent or Spouse Name _____ Is this person a patient Y/N

Person to contact in case of emergency _____ Phone _____

Insurance Information

Name of person responsible for this account _____ DOB _____

Address _____ City _____ State _____ Zip _____ Phone _____

Soc. Sec # _____ Relationship to patient _____ Drivers license # _____

Employer _____ Work phone _____ Full time Part time

Address of Employer _____ City _____ State _____ Zip _____

Name of Insured _____ Soc Sec # _____ DOB _____

Employer, Address, and Phone _____

Insurance Company _____ Member # _____

Relationship to patient _____ Is this person a patient Y/N

Do you have any additional insurance Y/N If Yes, Complete the following:

Name of Insured _____ DOB _____ Soc Sec# _____

Employer _____ Insurance Company _____ Member# _____

Who May We Thank For Referring You? _____

Nearest Friend or Relative Not Living With You _____

Your E-Mail address _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions have been accurately answered. I understand the providing incorrect information can be dangerous to my health. I authorize the dentist, Dr. R. E. O'Connor, to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependants.

X _____
Signature of patient (or parent if minor) Date