White Birch Oral Surgery
44C Dover Point Road
Dover, NH 03820

Patient's Name_____
Last First Initial

□ *Single* □ *Married* □ *Divorced*
How do you wish
To be addressed?_____

If Patient is a minor: Parent(s)
Name _____
Last First Initial

Date of birth_____

Does child live with both parents?
□Yes □No, Please explain_____
_____

Mailing Address
Street_____

City_____State_____Zip_____

Home Address (if different than above)
Street_____

City_____State_____Zip_____

Dental Insurance (Primary)

Employee Name_____

Employee Date of Birth_____

Employer_____

Name of Insurance Co:_____

Policy #_____

Group#_____

Dental Insurance (Secondary if applicable)

Employee Name_____

Employee Date of Birth_____

Employer_____

Name of Insurance Co._____

Policy #_____

Group#_____

Patient's Date of Birth_____

Social Security No._____

Home Telephone _____

Cell Telephone_____

E-mail Address_____

Patient/Parent Employer_____

Method of Payment for Patient Portion
□ *Cash* □ *Check* □*Credit Card* □*Care Credit*

Other Family Members in this Practice
_____
_____

Primary Dentist _____

Orthodontist_____

Someone to Notify in Case of Emergency
_____

Medical Insurance

Employee Name_____

Employee Date of Birth_____

Employer_____

Name of Insurance Co:_____

Policy #_____

Group#_____

Release:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advie and treatment provided for the purpose of evaluation and administering claim for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment f insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible to the accurarcy of the information on this page.

Patient and or Parent/GuardianSignature
X_____