Date:__________________

**NEW PATIENT / UPDATE INFORMATION**

Name ________________________________ Male/ Female ______________ Marital Status ___________

Address ____________________ City _________________________ State __________ Zip _______________

Social Security # _____________________ Date of Birth ________________________ Age ______________

Home# (    ) ___________________ Business# (    ) ___________________________ Ext. ______________

Mobile # (    ) ____________________________ E-Mail _______________________________________________

Employer's Name _________________________________________ Position _________________________

Name of Spouse ______________________________ Social Security # _______________________________

Address (If different from above) ________________________________________ Spouse DOB ____________

Spouse Employed by _________________________________________________________________________

Spouse Business Phone # (    ) _____________________ Ext. ________ Spouse Position ___________________

Spouse Mobile # (    ) _____________________ E-Mail _____________________________________________

Children Names & Ages ______________________________________________________________________

How did you hear about us? ___________________________________________________________________

Name, Address & Phone # of **local** emergency contact. _____________________________________________

_________________________________________________________________________________________

Chief Dental Concern ________________________________________________________________________

**PERMIT FOR TREATMENT**

**This is to certify that I, the undersigned, consent to the performing of dental and/ or oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures.**

Patient's (Parent's Signature) ___________________________________ Date: _______________________

**DENTAL INSURANCE INFORMATION**

Name of Insurance Company ______________________________

Policy Holder Name ______________________________

DOB ______________________________

SS# ______________________________

Employer Name ______________________________

Insurance Co. Phone # ______________________________

Policy # ______________________ Group#

***We will need a copy of insurance card and current Driver's License.***

**I understand that as a service (to me) Dr. Linger will assist me in processing my insurance claims. However, I am responsible for all fees in their entirety at time treatment is performed.**

Patient's (Parent's Signature) ______________________ Date: ______________