WELCOME TO PALMER DENTAL

Rodney J. Palmer, D.D.S., PLC
7221 E. Baseline Rd., Suite 102
Mesa, AZ 85209 (480) 984-0884

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check all boxes on the front and back of this form. This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you?

YES ☐ NO ☐

Email Address _____

1 Patient Information

Date _____

Patient _____

Address _____

_____

City State Zip

I prefer to be called: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other _____

Birthdate _____ Gender: F ☐ M ☐ Age _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____ - _____ - _____

If patient is a minor, give parent's or guardian's name: _____

_____

Occupation _____

Employer _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

2 Phone Numbers

Home Phone _____

Work _____ Ext _____

Spouse's Work _____

Family Physician's Name: _____

Physician's Phone: _____

IN CASE OF EMERGENCY, CONTACT (*Specify someone who does not live in your household.*)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

3 Dental Insurance

Who is responsible for this account? _____

SS# _____ Birthdate _____

Relationship to Patient: _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes ☐ No ☐

Subscriber's Name: _____

Insurance Co. _____

Group # _____

FORM 006327 R/08/10 ITEM 8101

4

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship to Minor (if Applicable) Date