

# Patient Information

Ross H. Dixon DDS

Date \_\_\_\_\_

Name \_\_\_\_\_ (Please circle all that apply) Male Female Minor Married Single  
Last First M

Address \_\_\_\_\_  
Street Apt. # City State Zip

Telephone (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Home # Work # Mobile #

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ E-Mail Address \_\_\_\_\_  
Month Day Year

SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Work E-mail Address \_\_\_\_\_

How may we contact you (Please circle all that apply) Home # Work # Mobile # Text E-Mail Work E-mail

Place of Employment \_\_\_\_\_ If Student, School / Grade \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Insurance Information

Primary Insured - Responsible Party (Please Circle) Patient Guardian Spouse Father Mother

\_\_\_\_\_  
Last First M Birthdate (MO/DAY/YEAR) Relationship to Patient

\_\_\_\_\_  
Employer Dental Insurance Company SS# Subscriber # Group #

## Secondary Insured

\_\_\_\_\_  
Last First M Birthdate (MO/DAY/YEAR) Relationship to Patient

\_\_\_\_\_  
Employer Dental Insurance Company SS# Subscriber # Group #

Person to Contact in Case of Emergency \_\_\_\_\_  
Name Phone #

## Authorization

I hereby authorize payment directly to Dr. Dixon 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, photographic 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 histories and other information about my dental treatment to third party payors and / or health professionals.

X \_\_\_\_\_  
Signature Date Driver's License #