

Mettler and Griego Family Dentistry

We would love to be your family dentist

Patient Information

Patient Name _____ Birth Date _____ Age _____

Preferred Name _____

Address _____ City _____ State _____

Home Phone _____ Cell Phone _____ Email Address _____

Work Phone _____ Social Security Number _____

Gender: Female ___ Male ___ Single ___ Married ___ Other ___

If patient is a minor, name of person with patient at exam _____ Relationship _____

If patient is a full time student, name of school _____ Location _____

How did you hear about our office? _____ Whom may we thank for referring you? _____

In case of an emergency, whom should we contact? _____ Phone _____

Responsible Party Information (if adult, please continue with Dental Information)

Mother's Name _____ Father's Name _____

Address _____ Address _____

Phone _____ Phone _____

If patient is a minor: Custodial Parent/Legal Guardian _____

Primary Dental Insurance

Subscriber _____

Name of Plan _____

Group # _____

ID # _____

Insurance Phone _____

Employer _____

Date of Birth _____ SSN _____

Work Phone _____

Medical Insurance

Subscriber _____

Name of Plan _____

Group # _____

ID # _____

Insurance Phone _____

Employer _____

Date of Birth _____ SSN _____

Work Phone _____

Minor/Child Consent

I, being parent or guardian of _____ do hereby request and authorize Mettler and Griego Family Dentistry to administer such medication and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through patient and doctor consultation. The information which appears on the dental and medical histories is correct to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

Signature on File

By signing this form, I authorize Mettler and Griego Family Dentistry to use this signature as authorization of all my insurance submissions. I authorize release of information to all my insurance carriers. I authorize payment be made directly to Mettler and Griego Family Dentistry. I permit a copy of this authorization to be used in place of an original claim form. I understand that I am Responsible for my bill and that Mettler and Griego Family Dentistry is acting as an agent to help me obtain payment from my insurance carrier.

Patient/Guardian Signature _____ Date _____