



Information (adult)

Name _____ I prefer to be called _____ Sex _____

Age _____ Date of Birth _____ Soc. Sec.# _____ Driver Lic.# _____

Home Address _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ Email Address _____

Employer _____ Occupation _____

What is the name/phone number of your previous dental office?

How would you like us to confirm your appointments? (Please circle one of the following)

Text Message	Email	Home Phone	Cell Phone	Work Phone
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Marital Status:

Single	Married	Separated	Divorced	Widowed	Remarried
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Spouse's Name _____ Date of Birth _____

Employer _____ Occupation _____ Work Phone () _____

EMERGENCY CONTACT:

Name _____ Relation _____

Home Address _____ Home Phone () _____

Person Responsible for Account (Circle one)	Self	Other
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IF "OTHER" FILL THIS SECTION:					
LAST NAME				FIRST NAME	
ADDRESS				BIRTHDATE	
CITY		STATE		ZIP	
DRIVERS LISCENSE #		Soc. Sec. #			

Dental Insurance: Primary					
Insurance Co. Name		Phone		Group/Policy #	
Employer		Insured's Name			
Member ID#		Soc. Sec.#		Date of Birth	

Dental Insurance: Secondary					
Insurance Co. Name		Phone		Group/Policy #	
Employer		Insured's Name			
Member ID#		Soc. Sec.#		Date of Birth	

I have reviewed the above medical and dental information, and find it accurate. If there are any later changes in my clinical history, I understand that it is my responsibility to inform Dr. Flannagan. I also give permission for Dr. Flannagan to perform a clinical examination and to make recommendations for treatment. *******I have chosen the dental provider: Dr. Flannagan, First Impressions Family Dental Care of my own free will.**

X _____ (please initial)

I certify that I am covered by _____ insurance company and I assign directly to Dr. Flannagan all insurance benefits otherwise payable to me.

I understand I am responsible for payment of services rendered and also responsible for paying any fees, co-payment and deductible that my insurance does not cover. I also agree to pay interest at the rate of 18% APR on any balance over 90 days from the date of service. I further agree to pay any collection fees, attorney fees, and court cost should these means of collection become required. **I understand I am responsible for any collection agency fees and/or a fee for missed appointments if sufficient notice is not given. If we have not received sufficient notice, a charge may be applied to your account.** The undersigned allows First Impressions Family Dental Care, PC to use patient photos (withholding all names) as educational tools within our practice. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Flannagan's "Notice of Privacy Act" –HIPPA Act and Dr. Flannagan's Office Policy.

X _____

Date: _____