

John R Burnett, III, DDS, MAGD

Full name: _____ Birth date: _____ Sex: Male Female

Name by which you wish to be called: _____ Social security #: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail: _____ Driver's license #: _____

Employee status: Full time Part time Retired Not employed

Employer: _____

Student status: Full time Part time Not a student

Marital status: Single Divorced Widowed Separated Married

Spouse's full name: _____

Who may we thank for referring you to this office? _____

Who is responsible for payment of this account? _____

What is the relationship of the responsible party to the patient? _____

Responsible party's information:

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Birth date: _____ Social security #: _____ Driver's license #: _____

Employed by: _____ How long: _____

Present position: _____

If responsible party is married:

Spouse's name _____

Spouse's address: _____

Spouse's phone: Home: _____ Work: _____ Cell: _____

Spouse's birth date: _____ Spouse's social security #: _____

Spouse employed by: _____ How long: _____

Present position: _____

I authorize the dentist and his staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administrating claims for insurance benefits or to another doctor. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of insurance benefits to the dentist, otherwise payable to me. I attest to the accuracy of the information on these pages.

I have received a copy of "Notice of Privacy Practices".

Patient's/guardian's signature: _____ Date: _____

Dental insurance: Yes No If yes, please fill out information on the next page.