

**ROBERT HALE, D.D.S., P.C.**

**PERSONAL INFORMATION**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Patient Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Patient Soc. Sec. No. \_\_\_\_\_ Marital Status: Married\_\_ Single\_\_ Widowed\_\_ Divorced\_\_  
Patient Name if Patient is a Child \_\_\_\_\_  
Mothers Date of Birth \_\_\_\_\_ Fathers Date of Birth \_\_\_\_\_  
Employed By \_\_\_\_\_ Hourly\_\_ Salary\_\_ Position \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Spouses Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Person Financially Responsible For Account \_\_\_\_\_  
Who Do We Thank For Your Referral \_\_\_\_\_

**\* DENTAL INSURANCE INFORMATION \***

Insured Person \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ Marital Status: Married\_\_ Single\_\_ Widowed\_\_ Divorced\_\_  
Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Employed By \_\_\_\_\_ Hourly\_\_ Salary\_\_ Position \_\_\_\_\_  
Active\_\_ Retired\_\_ Plant \_\_\_\_\_ Medical Ins. \_\_\_\_\_ Group No. \_\_\_\_\_  
Spouse Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Active\_\_ Retired\_\_ Plant \_\_\_\_\_ Hourly\_\_ Salary\_\_ Position \_\_\_\_\_  
Spouses Insurance Company \_\_\_\_\_ Spouses Soc. Sec. No. \_\_\_\_\_  
Group No. \_\_\_\_\_ Medical Ins. \_\_\_\_\_ Group No. \_\_\_\_\_

**\* UNDERSTANDING AND AGREEMENT \***

- I consent to treatment for the above patient.
- I authorize the release of all dental records to my insurance company if applicable.
- I allow fax transmittal of my dental records, if necessary.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to my treatment.
- I understand that dental benefits are not meant to cover the entire cost of treatment, nor do they cover all procedures. Any cost not covered will be my responsibility.
- I understand outstanding balances may be subject to financial changes.

\_\_\_\_\_  
SIGNATURE OF PATIENT/ LEGAL GUARDIAN

\_\_\_\_\_  
DATE