Patient Name ____ Date ________________________

SS# __________________________ Birthdate ______________ Cell Phone ____________________

Home Phone __________________ Work Phone ________________ Email _____________________

Address ____________________________________ City ___________________ Zip _____________

Employer Name ______________________________ Occupation _____________________________

Employer Address ___________________________ City ___________________ Zip _____________

Please list other family members we have seen: ____

I would like to receive patient reminders and newsletters by email: Yes or No (Please circle one)

INSURANCE INFORMATION

Dental Insurance Company Name ______________________________________

Ins. Co. Phone # ______________________ Insurance Patient ID # _________________________

Insured Name ________________________________ Relationship to Insured __________________

Insured SS# ____________________ Insured Birthdate _____________ Group# _________________

Insured Employer ________________________________ Occupation _________________________

Employer Address ___________________________ City _________________ Zip ___________

OTHER INFORMATION

In case of emergency, who would you like us to contact? ______________________________

Contact's Home Phone _____________ Work Phone ______________ Cell Phone ______________

Name of Your Physician ____________________ Name of Your Former Dentist _________________

How did you hear about our office? ____

PATIENT CONSENT

The undersigned hereby authorizes Dr. Logan's office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, therapy, and medication that may be indicated and further authorize and consent that the doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is payable at the time services are rendered. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to collect.

X____ X________________________________

Patient Signature Date