

Patient Information:

First Name: _____ MI: _____ Last Name: _____ Preferred: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SS #: _____ Sex: Female Male

Parent/Guardian's Names: _____ Alt. Address (if any): _____

E-Mail Address: _____ I would like to receive correspondences via e-mail.

Check preferred contact number:

Home: _____ Work: _____ Ext: _____ Cell: _____

Student Status: Full Time Part Time School Name: _____ City & State: _____

Emergency Contact Person: _____ Relationship to Patient: _____ Phone #: _____

Not Covered by Dental Insurance – Self Pay

Insurance Information: (If patient is the insurance policy holder, duplicate information fields may be skipped)

Primary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Secondary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Referrals: We would love to know how you were referred to us: Dental Website Insurance Company/Website Phonebook
 Mailer/Postcard Driving By/Window Patient or Provider: _____

Acknowledgements:

Minor / Child Consent: I am the parent / guardian of _____, and there are no court orders in effect that prohibit me from signing this consent. I hereby request and authorize Russell Street Dental Associates LLC to perform necessary dental services for the above named child including but not limited to diagnostic and/or preventative procedures, updating X-rays, administering anesthetics, and other treatment mutually agreed upon by me and as deemed advisable by the dentist. I hereby authorize Robert J. Gauthier, DMD and/or Russell Street Dental Associates LLC team to proceed with such dental services whether or not I am present at the time treatment is rendered.

Insurance Assignment / Release: I certify that the above named patient is covered as my dependent by insurance as specified and assign Russell Street Dental Associates LLC all insurance benefits, if any, otherwise payable to me for services rendered. Russell Street Dental Associates LLC may use and disclose health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Receipt of Notice of Privacy Practices: I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

Print Parent/Guardian Name _____, have provided accurate information to the best of my ability.

Signature of Parent/Guardian

Date