

Louisville Dental Associates

PATIENT INFORMATION

DATE _____

NAME: _____ MALE FEMALE MINOR SINGLE MARRIED

ADDRESS: Street: _____ City: _____ State: _____ Zip: _____

BIRTH DATE: (Mo/Day/Year) _____ PHONE (Home) (____) _____ (Office (____) _____)

EMPLOYER _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO

Whom may we thank for referring you to our office? _____

Why did you choose Dr. Lorenz, Dr. Carter or Dr. Steinbach for your dentist? _____

FAMILY INFORMATION

HUSBAND (OR FATHER)				WIFE (OR MOTHER)			
_____				_____			
Last	FIRST	M		Last	FIRST	M	
_____				_____			
STREET	CITY	ST	ZIP	STREET	CITY	ST	ZIP
_____				_____			
HOME PHONE #	WORK PHONE #			HOME PHONE #	WORK PHONE #		
_____				_____			
BIRTH DATE (MO/DAY/YEAR)	SS#			BIRTH DATE (MO/DAY/YEAR)	SS#		
_____				_____			
EMPLOYER				EMPLOYER			
_____				_____			
DENTAL INSURANCE CO.				DENTAL INSURANCE CO.			
GROUP #				GROUP #			

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household
Name _____
Address _____
City/State/Zip _____
Telephone # _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
 Patient Father (or Husband)
 Guardian Mother (or Wife)

METHOD OF PAYMENT

YOUR INSURANCE COPAY IS DUE AT TIME OF SERVICE

Payment in full at each appointment (cash or check)
 Payment in full at each appointment (VISA MC)
 DISCOVER AMX
Card# _____ Exp.Date _____

CONSENT

The undersigned hereby authorizes Robert M. Lorenz, D.D.S., or Rebecca L. Steinbach, D.D.S. to perform the examination (including any necessary X-rays) and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the undersigned. This consent shall remain in full force and effect until cancelled by either party.

Signature _____ Date _____