Red River Dental
William A. Puckett, Jr. DDS

Date: _____

Patient Information

Name: _____ Birthdate: _____ SS#: _____

Sex: Male Female Race: _____ Marital status: _____

Phone #: _____ Cell: Yes No Other #: _____ Cell: Yes No

Address: _____ City, State: _____ Zip: _____

Email address: _____ Employer/school: _____

Emergency contact name: _____ Phone number: _____

List anyone in your family already a patient here _____

Responsible Party

Responsible party: _____ Relationship to patient: _____

Phone number: _____ Birthdate: _____ SS#: _____

Insurance Information

Name of policy holder: _____ Birthdate: _____ SS#: _____

Insurance company: _____ Employer: _____

Medical History

Serious illnesses or operations? Yes No (please list with date) _____

_____

Diagnosed with any medical conditions? Yes No (please list) _____

_____

Drug allergies? Yes No (please list) _____

_____

Currently taking medication? Yes No (please list) _____

_____

Pregnant, nursing, or trying to get pregnant? Yes No (explain) _____

Dental concerns? Yes No (explain) _____

Authorization and Release

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my child, ever change in health. I certify that I, and/or my dependents, have insurance coverage and assign directly to Red River Dental all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. Red River Dental may use or disclose my health care information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end three years from the date signed.

_____ _____

Print name of patient, parent or guardian Signature of patient, parent or guardian