Patient Information (CONFIDENTIAL)

Name____Home Phone_____________________

Address____________________________________City______________State__________Zip Code__________

Date of Birth__________________________________ Sex: ❑M ❑F Soc. Sec. No________________________

Family Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School____Work Phone________________

Email Address__________________________ Emergency Contact__________________________( ) -______

Whom may we thank for referring you?____

Referral Source: ❑Practice Website ❑Google ❑Yelp ❑Bing ❑Ins. Plan ❑Valpak ❑Yellow Pages ❑Outdoor Sign
Referred by : ____

Referral Source: ❑Self ❑Parent ❑Step Parent ❑Grandparent ❑Sibling ❑Family Member ❑Babysitter
❑Guardian

Information about the dental office or healthcare organization authorized to release the information:

Name of Insured ____ Relationship to Patient__________________

Subscriber's Birthdate____________________________Soc. Sec. No.___________________________________

Name of Employer ____Work Phone________________________

Name of Dental Insurance Co. ____Group No.________________

Ins. Co. Address_____________________________City________________State________Zip code____________

Do you have additional dental insurance? ❑Yes ❑No If yes complete the following:

Name of Insured ____ Relationship to Patient__________________

Subscriber's Birthdate____________________________Soc. Sec. No.___________________________________

Name of Employer ____Work Phone________________________

Name of Dental Insurance Co. ____Group No.________________

Ins. Co. Address_____________________________City________________State________Zip code____________

I request and authorize the above-named dental office or healthcare organization to release the information specified below to Cherry Creek Family Dental.

Description of information to be released: Copy of all dental x-rays taken within the last 5 years

Information about the office where dental radiogrpahs should be sent:

Name: Summit Smiles Dental **Phone:** 303.627.5432
Email address: info@summitsmilesdental.com

Authorization and Release

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization is effective until such date that I choose to revoke it. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

Signature:____Date:___________________________