3450 Bainbridge Drive, Suite 570
Dallas, Texas 75237
972-709-7414

Welcome to our family's office.
To assist us in providing quality dental care, please complete the confidential information below.

PATIENT INFORMATION

Patient Name _____ Birth date_____
Mailing Address _____ City _____State _____ Zip _____
Home Phone _____Cell Phone _____Work Phone _____ Email_____

RESPONSIBLE PARTY

Name _____ Social Security # _____ Birth date_____
Mailing address _____ City _____ State _____ Zip _____
Home Phone _____Cell Phone _____Work Phone _____ Email_____
Employer_____ Occupation_____
Employer Address_____ City_____ State_____ Zip_____
Relationship of Patient to Responsible Party : ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

HOW DID YOU HEAR ABOUT US?

❑ Referred by _____ ❑ Website ❑ Facebook ❑ Twitter ❑ Sign/Advertisement: _____
❑ Other: _____

DENTAL INSURACE INFORMATION

Primary

Insurance _____ ❑ PPO ❑ HMO ❑ Insurance Plan ❑ No insurance
Insured's Name _____ Social Security # _____
Insured's Employer _____ Occupation _____
Group/Policy# _____ Insurance Phone # _____
Relationship of Patient to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary

Insurance _____ ❑ PPO ❑ HMO ❑ Insurance Plan ❑ No insurance
Insured's Name _____ Social Security # _____
Insured's Employer _____ Occupation _____
Group/Policy# _____ Insurance Phone # _____
Relationship of Patient to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

(Complete back)

(Complete back)

PHOTOGRAPHY RELEASE

I hereby authorize **Turner Family Dental** to publish photographs taken of me during my dental office visits, and my name and likeness, for use in the **Turner Family Dental's** print, online and video-based marketing materials, as well as other office publications.

I hereby release and hold harmless **Turner Family Dental** from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

I hereby release **Turner Family Dental**, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

I understand and agree with the Turner Family Dental policies, authorizations and notices **(initial ALL)**

_____ Appointment Policy

_____ Financial Policy

_____ General Consent to Treatment

_____ Release of Information Authorization

_____ Assignment of Insurance Benefits Authorization

_____ Notice of Privacy Practices

_____ Photography Release **(Check One)** **Yes** _____ **No** _____

_____

PRINT NAME

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**