



MICHAEL MORRISON, DDS
DENTISTRY BY DESIGN

Welcome! So that we may provide you with the best possible care,
Please fill this information form. All information is completely confidential.

PATIENT INFORMATION

DATE _____

NAME _____

LAST FIRST MIDDLE INITIAL NICKNAME

ADDRESS _____

STREET APT. #

CITY STATE ZIP

EMPLOYER _____ OCCUPATION _____

BIRTHDATE _____ DRIVER'S LICENSE _____

TELEPHONE HOME _____ SOCIAL SECURITY NUMBER _____

BUSINESS _____ MALE FEMALE

EMERGENCY: NAME _____ PHONE _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER
COMPANY NAME _____

ADDRESS _____
STREET CITY STATE ZIP

POLICY NUMBER _____ TELEPHONE _____

PRIMARY CARRIER
COMPANY NAME _____

ADDRESS _____
STREET CITY STATE ZIP

POLICY NUMBER _____ TELEPHONE _____

AUTHORIZATION

I hereby authorize payment directly to the Family Dental Center of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost and dental treatment. I hereby authorize Family Dental Center to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE _____ DATE _____

OTHER INFORMATION

SPOUSE/RESPONSIBLE PERSON NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET APT. #

CITY STATE ZIP

EMPLOYER _____ DRIVER'S LICENSE _____

BIRTHDATE _____

TELEPHONE BUSINESS / CELL _____ SOCIAL SECURITY NUMBER _____