Change your smile. Change your life.

Welcome and thank you for selecting our dental healthcare team!
We strive to provide you with the best possible dental care.
Please fill out this form completely in ink and sign at the bottom.

Patient or Guardian Information

First Name ________________ **Middle Name** _______________ **Last Name** ______________________

How do you wish to be addressed? _____________________________________ Male Female

Mailing Address ____

City _______________________ State _______ Zip _________________

Home Phone (____) __________Work Phone (_____) __________Cell Phone (_____) __________

Email Address ____

Birthdate ____/____/_____ Soc. Sec. # or Insurance ID _____________________________

Employer ______________________________________ Occupation _________________________

Employer Address ____

City _______________________ State _______ Zip _________________

If married, Spouse's Name ________________________ Employer ______________________________

Spouse Work Phone (_____)__________Cell Phone (_____)__________

Name(s) and Age(s) of children, if any ____

Person to contact in case of Emergency ____

Relationship ______________Daytime Phone (_____) __________Cell Phone (_____)__________

Medical Doctor's Name ____

Clinic Name & City_______________________________________Clinic Phone (_____)_________

How Did You Hear About Us? Advertising - Which Source ______________________________

OR Personal or Doctor Referral - Person's Name _______________________________________

Responsible Party, if different from above

First Name ________________ **Middle Name** _______________ **Last Name** ______________________

Relationship to Patient ____________________________

Home Phone (_____)__________Work Phone (_____) __________Cell Phone (_____) __________

Birthdate ____/____/_____ Soc. Sec. # or Insurance ID _____________________________

Employer ______________________________________ Occupation _________________________

Billing Address, if different from above ____

City _______________________ State _______ Zip _________________

Authorization and Release

I certify that the above questions have been accurately answered. I authorize Dr. Haag and his team to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize and request my insurance company to pay directly to Creekview Dental insurance benefits otherwise payable to me whenever possible. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____ ____________________

Signature of patient (or parent if minor) **Date**