Thank you for visiting Dr. Sonntag's office. We want your visit to be as comfortable and pleasant as possible! Please help us by completing this form.

PATIENT INFORMATION

Name: Last_____First_____ Middle Initial_____

Address: Street_____Apt. #_____

City_____ State_____ Zip_____

Birthdate: _____/_____/_____ Email: _____

Telephone#: Cell_____ Work_____ Home_____

Employer: _____ SS# _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Telephone # _____

INSURANCE INFORMATION:

Primary Dental Carrier:

Insured Name _____

Relationship to patient _____ Birthdate _____/_____/_____ SS#_____

Employer _____ Dental Ins. Co. _____

Subscriber # _____ Group# _____

Secondary Dental Carrier:

Insured Name _____

Relationship to patient _____ Birthdate _____/_____/_____ SS# _____

Employer _____ Dental Ins. Co. _____

Subscriber # _____ Group # _____

Authorization:

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.