Welcome to Pine View Family Dental! We appreciate the confidence you have placed in us to care for your dental needs.

Date:_____ Patient Name:_____
Preferred Name:_____M ___ F___DOB: _____

Age:_____ SSN:_____

Married ____ Single ____ Child ____ Other ____ Email: _____

Home Address: _____

City/State/Zip: _____

Billing Address (If Different): _____

City/State/Zip: _____

Home#: _____ Work#: _____

Cell #: _____Text Messages OK: Y N

Spouses Name: _____ Phone # _____

Primary Dental Ins: _____

Subscriber Name: _____Subscriber DOB: _____

Subscriber SS#/Dental Insurance ID#_____

Subscriber Address:_____

City/State/Zip:_____

Ins. Phone #: _____ Group #: _____

ID/SSN: _____Employer:_____Emp ph# _____

Please inform us if you have secondary dental insurance.

Emergency Contact:_____Ph#: _____

How did you hear about us: _____

I hereby authorize the use of x-rays, pictures, anesthesia, nitrous oxide and/or any other medication necessary for dental treatment today/future. Our standard of care is to take bitewing x-rays once per year and full-mouth/pano x-rays once every five years. Please remember a parent/guardian is required to remain in the office during children's treatment. There will be a $50 fee per hour of scheduled appointment time that is cancelled without 48 hours notice given. By signing this, you agree to the terms listed above. Thank you!

Signature: _____ Date: _____

Guarantor/Parent: _____ Date: _____