



Michael J. Giesy, DMD
 6004 Westgate Blvd., Suite 210
 Tacoma, WA 98406
 (253) 752-6630

Patient's Name	Nickname	Social Security Number	Today's Date	Date of Birth
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Address	City	Zip	Home Phone
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Patient's Occupation	Employer	Work Phone Ext.	Cell Phone
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Age	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Children _____	E-Mail Address
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Referred by	Spouse's Name
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Please fill in this section only if person responsible for this account is different than patient	Cell Phone	Social Security Number	Relationship To Patient	Spouse <input type="checkbox"/> Other <input type="checkbox"/> _____
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Name	Work Phone	Home Phone	Employer	Work Phone	Ext.
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Address	Address
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City	State	Zip
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Dental Insurance Information Uninsured <input type="checkbox"/> <input type="checkbox"/> Single Coverage Double Coverage <input type="checkbox"/>	As a courtesy to our patients, we are happy to submit your dental insurance for you; however, the expenses incurred are your responsibility.
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Primary Dental Insurance	Name of Insured (Subscriber)	Birthdate	Social Security Number (Subscriber)	Relationship To Patient	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/> _____
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Name of Insurance Company	Group Number	Insurance Company Phone Number
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Address

City	State	Zip	Employer
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Secondary Dental Insurance	Name of Insured (Subscriber)	Birthdate	Social Security Number (Subscriber)	Relationship To Patient	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/> _____
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Name of Insurance Company	Group Number	Insurance Company Phone Number
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Address

City	State	Zip	Employer
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Name of Nearest Relative	Address	Phone #
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I hereby grant authority to the Attending Dentist to administer treatment, and to administer such anesthesia, including nitrous oxide, deemed necessary or advisable. I understand that dental injections may cause muscle soreness, temporary and/or permanent anesthesia.

X _____
 Signature Date

Assumption of Responsibility Agreement

I, _____ agree to be responsible for the dental expenses
 Name

of, _____ my _____
 Patient Relationship

X _____
 Signature Date