George A. Turner, D.D.S

PREVENTIVE AND RESTORATIVE CARE FOR ADULTS AND CHILDREN

1903 Cypress Creek Rd., Ste. 104 | Cedar Park, TX 78613
512.258.8381 Fax 512.401.2580 | drgturner@sbcglobal.net

Date ______________________

1. **Patient's Name** ______________________ Driver's License # ______________________
   Last First Middle
2. Address Street ______________________
   Street City State Zip Code
3. Home Phone ______________ Birth Date ______________ Social Security # ______________
4. E-mail Address ______________ Cell Phone ______________ Work Phone ______________

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5. **Person Responsible for Payment** ______________________
   Last First Middle
6. Address ______________________
   Street City State Zip Code
7. Relationship to Patient ______________________
8. Social Security # ______________________
9. Birth Date ______________________
10. Driver's License # ______________________
11. Home Phone ______________________
12. Employer ______________________
13. Work Phone ______________________

If minor, list parent's names & phone #'s:

Father ______________________
First Last #
Mother ______________________
First Last #

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5. **Patient's Spouse Name** ______________________
   Last First Middle

15. Spouse's Employer ______________________
16. Occupation ______________________
17. Work Phone ______________________

DENTAL INSURANCE INFORMATION (need copy of card)

18. Insured's Name ______________________
19. Insured's Birth Date ______________________
20. Insured's Address (if different from above) ______________________
21. Insured's Social Security # ______________________
22. Insured's Employer ______________________
23. Insurance Company Name ______________________ Group Name ______________________
24. Insurance Address ______________________

EMERGENCY INFORMATION

25. Local Friend or Relative not living with you ______________________
26. Complete Address ______________________
27. Phone Number ______________________

GETTING TO KNOW YOU

28. Why did you select our office? ______________________
29. Whom may we thank for referring you? ______________________
30. Is another member of your family or relative a patient in our practice? ______________________

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, full explanation of the procedure (s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

PRIVACY POLICY

I have chosen NOT to receive a copy of the privacy. I understand a copy is available at any time.

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Patient's, Parent's or Guardian's Signature Date