COMPASS DENTAL
NAVIGATION TO YOUR BEST ORAL HEALTH
Dr. Ryan Sigmon

Patient Information

First: _____ Middle: _____ Last: _____ Preferred Name: _____

SS#: _____ Date of Birth: _____/ _____/ _____ Marital Status: Single / Married / Widowed / Divorced

Phone (H): _____ (W): _____ (C): _____

Home Address: _____ City: _____ Zip code: _____

Employer: _____ Spouse's Name: _____ Phone: _____

Email Address: _____ Preferred Pharmacy: _____

Employer: _____ Job title: _____

In case of emergency, please contact: _____ Phone: ___-___-____Relationship: _____

Responsible Party Information *(If someone other than the patient)*

First: _____ Middle: _____ Last: _____ Preferred Name: _____

SS#: _____ Date of Birth: _____/ _____/ _____ Marital Status: Single / Married / Widowed / Divorced

Phone (H): _____ (W): _____ (C): _____

Home Address: _____ City: _____ Zip code: _____

Family members who are current patients of Compass Dental: _____

Patient signature (or legal guardian): _____ Date: _____ / _____/ _____

How did you hear about our office? Google/Internet/Phone Book/Doctor Referral/Staff/Patient:_____

INSURANCE INFORMATION

Insured's name: _____ Relationship: _____

Insured Employer: _____ Insured's SS#:____-____-_____ DOB: ___ /___/_____

Insurance Company: _____ Phone Number: ____-____-_____

Member Number: _____ Group #: _____

TREATMENT CONSENT

I request the performance of dental services for myself or the above named patient by Dr. Ryan Sigmon, DMD and any supervised staff member. I give my consent to any advisable dental procedures, medications, and therapies that are necessary in the performance of these dental services. I understand dental anesthetics are routinely used and embody the risk of mild allergic reaction, permanent numbness and even anaphylactic shock. In keeping with current HIPAA regulations I consent to the release of information contained in my or the above named patient's dental records to my medical and/or dental insurance company for claims processing. I further consent to the release of information in consultation with dentists, dental laboratories, medical physicians, and hospitals to facilitate dental treatment.

Patient signature: _____ Date: _____ / _____/ _____