



Dr. David Bishop and Dr. Robert Kim

1104 N. GREENVILLE AVENUE, ALLEN, TEXAS 75002 972.727.8249

Date _____

1. **Patient Name** _____ Driver's License # _____
LAST FIRST MIDDLE
2. Address _____
STREET CITY STATE ZIP
3. Home Phone _____ Birthdate _____ Social Security # _____
4. E-Mail Address _____ Cell # _____ Work Phone _____
5. **Person Responsible for Payment**
6. Address _____
7. Relationship to Patient _____
8. Social Security # _____ (if minor, list parent's names:)
9. Birthdate _____ Father _____
First Last
10. Driver's License # _____ Mother _____
First Last
11. Home Phone _____
12. Employer _____
13. Work Phone _____
14. **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 (employee) _____
19. Insured's Birthdate _____
20. Insured's Address (if different from above) _____
21. Insured's Social Security # _____
22. Insured's Employer _____
23. Insurance Co. Name _____ Group Name _____
24. Insurance Address _____

EMERGENCY INFORMATION

25. Local Friend or Relative no living with you _____
26. Complete Address _____
27. Phone No. _____

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 of relative a patient in our practice? _____
31. When was your last dental visit? _____
32. When was the last time you had complete dental X-rays taken? _____ Dentist _____
33. Have you ever had any teeth removed? _____
 How long have these teeth been missing? _____
 Have these teeth been replaced? _____
 How? Bridge Denture Implants _____

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 information above and further authorize and consent that the doctor chooses and employs assistants as he/she deems it. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by the doctor and/or his/her staff. I agree to pay for all services rendered by this office.

SIGNITURE OF RESPONCIBLE PARTY _____ RELATIONSHIP _____ DATE _____