DR. KARLYN TAYLOR, DDS

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Welcome to Central Park Dental, we appreciate you choosing our office for your dental and oral health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take a moment to complete this information form as thoroughly as possible.

PATIENT INFORMATION

Full Name____

Preferred Name____ Home Phone ____________________

Address____ Cell Phone______________________

City________________________State__________Zip________________ Work Phone_____________________

Email Address____ Date of Birth_____________Sex M F

How did you hear about us? ________________________________ Social Security #__________________

Is Patient the responsible party? Yes No If no, please fill out the information below:

Responsible Party Name____________________________________ Relationship to Patient_____________

Address____ Phone #_________________________

City________________________State__________Zip________________ Date of Birth_____________Sex M F

Email Address____ Social Security #__________________

Name and phone # of emergency contact____

INSURANCE INFORMATION

Do you have Dental Insurance? Yes No

Name of Insured____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Social Security # of Insured_________________________________ Insured Date of Birth________________

Insurance Company Name__________________________________ Group No_______________________

Address____ Effective Date____________________

City________________________State__________Zip________________ Subscriber ID____________________

Employer Name____ Your Position_____________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

I hereby authorize Dr. Karlyn Taylor and Central Park Dental to provide dental services deemed necessary or beneficial for my oral health. I understand that treatment options will be explained to me so that I may make an informed decision regarding my dental care or the dental care of a dependent. I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

____ ____________________________

Patient's (Guardian's) Signature Date