Russell K. Kirk D.D.S., P.C.
1409 West Baddour Parkway
Suite F
Lebanon, TN 37087

Patient Information

Name: _____ Birthdate: _____ Sex: _____
Last First Middle

Home Address: _____
Street City State Zip

Patient SS#_____ Drivers License #: _____ Martial Status: _____

Patient Employer/School: _____Occupation:_____

Phone # _____Cell #_____ Work # _____Ext_____

Insurance Information

Responsible Person: _____ Birthdate: _____
Last First Middle

Address: _____
Street City State Zip

Home#: _____ Work#: _____

Relationship to Patient: _____ SS#:_____

Employer: _____ Position: _____

Employers Address: _____
Street City State Zip

Insurance Company: _____ Group#: _____

Contact #: _____Effective Date: _____

Emergency Contact (Please list relative or friend not living with you.)

Name: _____Home #: _____Work # _____
Last First Middle

Home Address: _____ Employer: _____

Legal Responsible Party. If the patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

Consent for Laboratory Testing. In the event that any of the office staff of Russell K. Kirk, D.D.S., P.C. is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), Dr. Kirk has my full consent to draw blood for the purpose of laboratory testing. This will ensure the safety of all parties who are concerned and involved.

_____ _____
Patient's Signature/Responsible Party Date