PATIENT INFORMATION

PATIENT'S NAME ______________________ DATE ____________

ADDRESS ______________________

CITY ______________________ STATE ____________ ZIP ____________

PATIENT'S PHONE ______________________ CELL PHONE ____________

EMPLOYER ______________________ WORK PHONE ____________

EMPLOYER'S ADDRESS ______________________

DATE OF BIRTH ______________________ AGE ____________ ❑ MALE ❑ FEMALE

SOC. SEC. # ______________________ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW

EMERGENCY CONTACT NAME ______________________ PHONE ____________

DENTIST ______________________
First Name Last Name

PHYSICIAN ______________________
First Name Last Name

DATE OF LAST PHYSICAL ______________________

WHO REFERRED YOU TO THIS PRACTICE ______________________

(*PLEASE PRESENT ALL INSURANCE CARDS OR FORMS*)

PRIMARY DENTAL INSURANCE COMPANY ______________________

SECONDARY DENTAL INSURANCE COMPANY ______________________

PRIMARY MEDICAL INSURANCE COMPANY ______________________

SECONDARY MEDICAL INSURANCE COMPANY ______________________

POLICY HOLDER RESPONSIBLE FOR ACCOUNT ABOVE

NAME ______________________ RELATIONSHIP TO PATIENT ____________

ADDRESS (IF DIFFERENT) ______________________

CITY ______________________ STATE ____________ ZIP ____________

HOME PHONE ______________________ WORK PHONE ____________

EMPLOYER'S NAME ______________________

EMPLOYER'S ADDRESS ______________________

DATE OF BIRTH ______________________ AGE ____________ ❑ MALE ❑ FEMALE

SOC. SEC. # ______________________ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW

PAYMENT IS DUE AT THE TIME OF SERVICE. If we are filing insurance, you will need to pay your co-pay. In certain cases a payment plan may be arranged. This must be done BEFORE services are rendered. ALL ACCOUNTS MUST BE PAID WITHIN 30 DAYS.

I will pay today by ❑ Cash ❑ Check ❑ MC/Visa ❑ Discover

OVER