ACQUAINTANCE INFORMATION

Patient Information

Date _____

Patient Name _____
Last First Middle Preferred Name

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Email _____

How did you learn about our office? _____

List other immediate family members who are patients _____

Responsible Party Information

Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Email _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

Spouse's Name _____ Work Phone _____
Last First Middle

Employer _____ Occupation _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Insurance Co.Phone _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone # _____ Relationship to Patient _____

INSURANCE: Our office is happy to file your insurance claims as a courtesy to you. Each patient will be responsible for all fees not covered by insurance. We offer a variety of financial arrangements to suit everyone's budget.

Signature _____ Date _____