

PATIENT INFORMATION

METHOD OF PAYMENT

- Care Credit
- Cash
- Check
- Master card/Visa/Discover

Please Print

DATE: _____

Name of Patient: _____

Home Phone #: _____

Address: _____

Work Phone #: _____

City/State: _____ Zip Code: _____

Date of Birth: _____

Social Security #: _____ - _____ - _____ Sex: Male Female

Marital Status: M S D W

Parent or responsible Person: _____

Work Phone #: _____

Email Address: _____

Dental Insurance: _____

Group or Payroll #: _____

Secondary Dental Insurance: _____

Group or Payroll #: _____

Is the Patient Employed? Yes No

Name of Employer: _____

Address: _____

City/state/Zip Code: _____

Is the Patient a Full-Time Student? Yes No

Name of School: _____

Name of Insured (if other than patient): _____

Name of Employer: _____

Birth Date of Insured: _____ Social Security # of Insured: _____ - _____ - _____

How did you hear about our practice?

Friend or Relative: _____ (Name: _____)

Doctor/Dentist: _____ (Name: _____)

Other: _____ (Name: _____)

Name of Your Dentist: _____

Address and Phone #: _____

The doctor and staff will greatly appreciate your courtesy in keeping all appointments promptly. A fee of \$35 will be charge to your account for failed appointments or cancellations with less than 24 hr. notice.

Emergency contact person and phone number _____

Signature: _____