PATIENT INFORMATION

PATIENT

DR.
MR.
MRS.
MISS ______________________________

PATIENT | LAST NAME | FIRST NAME | MI. | DATE OF BIRTH

MAILING ADDRESS | STREET | CITY | STATE | ZIP

STREET ADDRESS (IF DIFFERENT) | STREET | CITY | STATE | ZIP

SPOUSE'S NAME | PATIENT'S SOCIAL SECURITY # | HOME PHONE #

PATIENT'S EMPLOYER | EMPLOYER'S ADDRESS | BUSINESS PHONE #

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU | RELATIONSHIP | PHONE #

REFERRED BY | GENERAL DENTIST

INSURANCE

COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE
AND PRESENT INSURANCE FORM TO RECEPTIONIST

	Insurance Company Name	Policyholder (Subscriber)	Policy / Certificate Number and Subscriber Number
1.			
2.			

RESPONSIBLE PARTY

DR.
MR.
MRS.
MISS ______________________________

LAST NAME | FIRST NAME | MI. | RELATIONSHIP TO PATIENT

MAILING ADDRESS | STREET | CITY | STATE | ZIP

HOME PHONE # | BUSINESS PHONE # | OCCUPATION

EMPLOYER | EMPLOYER'S ADDRESS

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services.

Preferred method of payment : ☐ Cash ☐ Check ☐ Credit Card (MasterCard/Visa/American Express)

DATE | SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY

COMPLETE REVERSE SIDE