PATIENT INFORMATION (CONFIDENTIAL)

Name_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security # _____

Check appropriate box: ☐ Minor ☐ Married ☐ Single ☐ Other

Patient's or Parent/Guardian's Name_____ Employer_____

Spouse's name_____ Spouse's phone #

_____

Contact information

Cell # _____ Home # _____ Work # _____

Email _____

Emergency Contact: Name_____ Phone #_____

INSURANCE

Does this patient have dental insurance? ☐ Yes ☐ No

Insurance Carrier _____

Name of policy holder_____ Policy holder's birthday_____

*Policy holder's member ID_____ OR *Social Security #_____

***necessary information to verify dental benefits**

Secondary insurance? ☐ Yes ☐ No

Insurance Carrier_____

Name of policy holder_____ Policy holder's birthday_____

*Policy holder's member ID_____ OR *Social Security #_____

RESPONSIBLE PARTY (signature required)

The responsible party is the person financially responsible for patient's account. This person will receive all billing statements.

Name of responsible party_____ Relationship to patient_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security # _____

Cell #_____ Home #_____ Work #_____

Driver's License #_____ OR Military ID # _____

***Please provide at least one of these forms of ID's at check-in or through electronic form**

X _____

Signature of **PATIENT** or **PARENT/GUARDIAN** of minor

OR

X _____

Responsible party**, IF different**