

GETTING TO KNOW YOU

To provide you with the best possible care, please fill out this confidential form completely.

PATIENT INFORMATION

Name _____ Date _____

Address _____ Date of Birth _____

Telephone () _____ Cell () _____

Social Security# (optional) _____ Drivers License# _____

Employer _____ Telephone { } _____

May we call you at work? { } Yes { } No Email Address _____

Spouse _____ DOB _____ Children _____ DOB _____
DOB _____
DOB _____

Employer _____ Telephone { } _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

(If same person as above, write "SAB")

Name _____ Address _____

Telephone { } _____ DOB ___/___/___ Relationship to Patient _____

Person to Contact in case of an Emergency

Name _____ Phone { } _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ ID _____ Group# _____

Plan(insurance) Name _____ Phone No. { } _____

Additional Dental Insurance? If so, please complete the following:

Name of Insured _____ ID _____

Group # _____ Plan {insurance} Name _____ DOB _____

Who may we thank for this referral? _____