PATIENT INFORMATION

CHART #_____

PATIENT

Name _____ (Last) (First)

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone ( ) _____

Cell/Pager ( ) _____

E-mail _____

Social Security # _____

DL# _____

Age _____ Birthdate _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____ (Last) (First)

Address _____ Apt. # _____

City _____ Zip _____

How long at this address? _____

Phone ( ) _____

Social Security # _____ DL# _____

Relationship to Patient _____

Age _____ Birthdate _____

EMPLOYMENT

Occupation _____

Employer _____

How Long? _____

Business Address _____

City _____ Zip _____

Business Phone ( ) _____ Ext. # _____

Verified By _____ Date _____

(Office use only)

REFERENCES

Name _____ (Last) (First)

Phone ( ) _____

Name _____

Phone ( ) _____

Spouse's Name _____

Spouse's Work Phone ( ) _____ (Last) (First)

PERSON TO CONTACT FOR EMERGENCY

_____ (Last) (First)

Phone ( ) _____

Physician _____ Phone ( ) _____

GETTING TO KNOW YOU

Do you have family members who may need dental care?
If so, please list name & relationship (son, daughter, husband)

1: _____ 2: _____

3: _____ 4: _____

How did you hear about our office? (Check one)

- ☐ Family-Friend (480)
- ☐ ConfiDent® (440)
- ☐ Newspaper (470)
- ☐ Billboard (050)
- ☐ Flyer-Coupon (480)
- ☐ Office Sign (420)
- ☐ Office Transfer (430)
- ☐ Insurance Plan (460)
- ☐ Television (020)
- ☐ Radio (030)
- ☐ Yellow Pages (120)
- ☐ Direct Mail-Postcard (480)
- ☐ Internet-Website (190)

I want information in Spanish: YES_____ NO_____

INSURANCE / DENTAL PLAN

Primary: ☐ Insurance ☐ PPO ☐ HMO (Check one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: ☐ Insurance ☐ PPO ☐ HMO (Check one)

Plan Name _____

Address _____

City, Zip _____

Insurance / Plan Phone # _____

Employer _____

Union/Local _____ Group # _____ Plan# _____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____ Date
Signature of Responsible Party or Patient
(Parent if Patient is a Minor)

SN 101 Rev. (08/10)

(COMPLETE BOTH SIDES)