

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? (Circle one)

Family-Friend (400)	Insurance Plan (460)
ConfIDent® (440)	Television (620)
Newspaper (470)	Radio (030)
Billboard (050)	Yellow Pages (120)
Flyer-Coupon (490)	Direct Mail-Postcard (480)
Office Sign (420)	Internet-Website (190)
Office Transfer (430)	

I want information in Spanish: YES _____ NO _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle 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 (Circle 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.

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