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 ______________________________
Last First

Spouse's Work Phone (   ) ______________________

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 (020)**
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)