ESSENTIAL DENTAL CARE

PATIENT INFORMATION

Today's Date: _____ Reason for visit: _____

Name: _____
Last First M.I.

Sex: M F Date of Birth: _____ Age: _____ Social Security Number: _____

If patient is a minor, parent's or guardian's name: _____

Residence Address: Street: _____ City: _____ ST: _____ Zip: _____

Mailing Address: Street: _____ City: _____ ST: _____ Zip: _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Other Phone (_____)_____ Email Address: _____

Marital Status: _____ Employer: _____

Whom do we have to thank for referring you to our office? _____

EMERGENCY INFORMATION
RELATIVE <u>NOT</u> LIVING WITH YOU

Name: _____ Relationship to patient: _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Dental Insurance Information
(Primary Carrier)

Insurance Company: _____
Insurance Company Phone: (_____)_____
Subsriber's Name: _____
Subscriber's DOB: _____
Subscirber's SS Number: _____
Subscriber's Group Name: _____
Subscriber's Group Number: _____
Subscriber's Employer: _____

Dental Insurance Information
(Secondary Carrier)

Insurance Company: _____
Insurance Company Phone: (_____)_____
Subsriber's Name: _____
Subscriber's DOB: _____
Subscirber's SS Number: _____
Subscriber's Group Name: _____
Subscriber's Group Number: _____
Subscriber's Employer: _____