ACQUAINTANCE INFORMATION

Patient Information

Date_____

Patient's Name _____
Last First Middle

Preferred Name_____ Birthdate_____

Address _____
Street City State Zip

Telephone _____/_____/_____ Social Security #: _____
Home Work Cell

Email: _____

How did you learn about our office?_____ Family Dentist: _____

If from a friend or relative, his/her name_____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone _____

Previous Address *(if less than 3 yrs.)*_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Employer_____ Occupation_____ No. Years Employed _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Insurance Information

Policyholder's Name _____Policyholder's Soc. Sec.# _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address _____

Policyholder's Employer_____ ID#_____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Policyholder's Name_____ Policyholder's Soc. Sec.# _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address_____

Phone_____

In order to protect my dental health, I authorize you to contact me by phone, text and email as needed. If I am on the national or state Do Not Call Registry, this authorization applies to time guidelines beyond those stated in the Do Not Call Registry(s).

I understand that where appropriate, credit bureau reports may be obtained.

Signature *(Parent's signature if minor)* _____

Updates *(date & initial)* _____ _____ _____ _____ _____