SCANDIA FAMILY DENTAL ACQUAINTANCE INFORMATION

Patient's name_____Date_____

Address_____

Telephone numbers: Home:_____Cell:_____Work_____

Social Security Number_____Birthdate_____Preferred name_____

Email Address_____How did you hear about our office_____

Previous Dentist office_____Is there current films with them Yes____No____

RESPONSIBLE PARTY INFORMATION

Name_____Marital status_____

Address_____

Telephone numbers: Home:_____Cell:_____Work:_____

Social Security Number_____Birthdate_____Relation to patient_____

INSURANCE INFORMATION

Policyholder's name_____Policyholder's ID#_____

Insurance company_____Group #_____Local#_____

Insurance company address_____Phone number_____

Do you have dual insurance? Yes____No____ If yes:
Policyholder's name_____Policyholder's ID#_____

Insurance company_____Group #_____Local#_____

Insurance company address_____Phone number_____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you_____Phone #_____

Signature(Parent's signature if minor)_____

APPOINTMENT CANCELLATION

If you need to make a change or cancel an appointment. 24 hour cancellation notice is appreciated.