PATIENT INFORMATION

Full Name:_____
Address:_____ City:_____
State:_____ Zip:_____ Sex:_____ Age:_____ DOB:_____
Patient Soc. Sec. #_____Home Phone:_____
Business Phone:_____ Cell:_____
Emergency Contact Name and Phone #_____

Referred by:_____
Last visit to dental office:_____ Physician's Name_____
Physcian's Address_____ Physcian's Phone:_____
Patient Employer:_____ Employer Phone:_____
Employer Address:_____
Marital Status: S M W D Spouse Name:_____
Spouse Employment:_____ Phone :_____
Employement Address:_____Spouse SS#_____
Spouse DOB:_____

IF PATIENT IS A CHILD, FILL OUT THE FOLLOWING:
Father:_____ Employer :_____
Employer Phone :_____ Father's SS#_____
Father's DOB:_____
Mother:_____ Employer:_____
Employer Phone:_____ Mother's SS#_____
Mother's DOB:_____

DENTAL INSURANCE

Insured Name:_____ Relationship to patient_____
Insured's Address(If different from patient)_____
Insured's DOB:_____ Insured's SS#_____
Insured's Employer:_____
Insurance plan name_____
Group #_____ Insurance phone #_____
Insurance Address:_____

I authorize payment of my dental benefits to Dr. Smith/Dr. Manus
Signature_____
Full payment by cash, check, or credit card is expected at the time services are rendered unless previous arrangements have been made.