South Shore DENTAL CARE

Patient Information

Print

TODAY'S DATE _____

LAST NAME _____ FIRST NAME_____ M.I._____

ADDRESS _____

CITY _____ STATE_____ZIP CODE_____

HOME PHONE (____) _____CELL/DAY TIME PHONE (____) _____

E-MAIL_____ALTERNATIVE E-MAIL_____

MALE/FEMALE DATE OF BIRTH _____ SS #_____ DRIVER LI.#_____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

SPOUSE'S NAME _____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER'S NAME _____WORK PHONE (____) _____Ext:____

REFERRED TO OUR OFFICE BY _____

PERSON RESPONSIBLE FOR ACCOUNT (if different from patient information):

LAST NAME _____ FIRST NAME_____ M.I._____

ADDRESS _____

CITY _____ STATE_____ZIP CODE_____

HOME PHONE (____) _____CELL/DAY TIME PHONE (____) _____

E-MAIL_____ALTERNATIVE E-MAIL_____

MALE/FEMALE _____ DATE OF BIRTH _____ SS#_____ DRIVER LI. #_____

EMPLOYED BY: _____WORK PHONE# (____) _____

RELATIONSHIP TO PATIENT SELF ☐ SPOUSE ☐ PARENT ☐ OTHER ☐

INSURANCE INFORMATION OR PAYMENT INFORMATION

Are you a self-pay patient? ☐ YES ☐ NO Do you have insurance? ☐ YES ☐ NO

PRIMARY INSURNACE: _____

POLICY #:_____ GROUP #:_____

Whom can we thank for your visit? _____

How did you locate us or get our number: ☐ Phonebook ☐ Internet ☐ Newspaper ☐ TV Advertisement