NAME:

Last *First* *M.I.* *Preferred*

ADDRESS:

Street or PO Box *City* *State* *Zip Code*

Single
Married
Child

BIRTH DATE** (mm/dd/yyyy) :* ***Social Security #

E-mail:

PHONE NUMBERS:

HOME:

CELL:

WORK:

Patient Employer *Employer Phone #*

PERSON RESPONSIBLE FOR BILL *RELATIONSHIP TO PATIENT* *SSN:*

DOB (mm/dd/yyyy):

ADDRESS & PHONE # FOR RESPONSIBLE PARTY (if different from patient)

INSURANCE INFORMATION

PRIMARY *Policy Holder's Full Name* *Relationship to Patient*

Policy Holder Social Security # *DOB (mm/dd/yyyy):* *Policy Holder Address (if different than patient)*

Insurance Company Name

Policy Holder's Employer *Employer Phone #*

SECONDARY *Policy Holder's Full Name* *Relationship to Patient*

Policy Holder Social Security # *DOB (mm/dd/yyyy):* *Policy Holder Address (if different than patient)*

Insurance Company Name

Policy Holder's Employer *Employer Phone #*

GETTING TO KNOW YOU

1. Is another member of your immediate family (living at the same address) a patient in our practice? If yes, whom?

2. Whom may we thank for referring you?

3. Person to contact for emergency: *Phone Number:*

HIPAA PRIVACY CONTACTS

I am providing written permission for Centerburg Dental Care to speak to, or leave messages at, any of the following numbers regarding my dental appointments and/or treatment.:

Name: _____ *Name:*

Phone #: _____ *Phone #:*

Relation: *Relation:*

_____ _____ _____

Signature of Responsible Party Relationship Date