Salud Family Dental CENTER

Patient Information

Thank you for choosing Salud Family Dental Center. Please complete this form in ink and print your answers. If you have any questions, please do not hesitate to ask one of our staff.

Name _____ Date ___/___/___
First Name MI Last Name

Address _____

City _____ State _____ Zip _____

Birthdate _____ □ Male □ Female Home Phone# (____) _____

Cell Phone# (____) _____ Work Phone# (____) _____

Where do you prefer to take calls: □ Home □ Cell □ Work

May we contact you by E-mail? □ Yes □ No E-mail Address _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Social Security # _____ Drivers License # _____ State _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Spouse's Name _____ Workplace _____

If you are a student, name of school _____ City/State _____

How did you hear about our office? _____

Who may we thank for referring you? _____

Closest relative not living with you & their phone number _____

Emergency Contact _____ Phone# (____) _____

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account _____

Relationship to patient _____ Phone # (____)_____

Address of Employer _____

City _____ State _____ Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate ___/___/___ Subscriber Social Security # _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____

Do you have additional dental insurance? □ Yes □ No If yes, Please complete the following:

Insurance Co. _____ Group # _____

Subscriber ID # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Company Phone # (____) _____