ACQUAINTANCE INFORMATION

Patient Information

Date_____

Patient's Name _____
Last First Middle

Preferred Name_____ Birthdate _____

Address _____
Street City State Zip

Telephone _____/_____/_____ Social Security #: _____
Home Work Cell

Email:_____

How did you learn about our office?_____ Family Dentist: _____

If from a friend or relative, his/her name _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address *(if less than 3 yrs.)* _____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name _____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Insurance Information

Insured's Name_____ Insured's Soc. Sec.# _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name_____ Insured's Soc. Sec.# _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address _____

Insured's Employer_____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone_____

In order to protect my dental health, I authorize you to contact me by phone as needed. If I am on the national or state Do Not Call Registry, this authorization applies to time guidelines beyond those stated in the Do Not Call Registry(s).

I understand that where appropriate, credit bureau reports may be obtained.

Signature *(Parent's signature if minor)* _____

Updates *(date & initial)* _____ _____ _____ _____ _____