Patient Information

First Name: ________ Last Name: ________ Middle Initial: ________

Patient is: ☐ Policy Holder Preferred Name: ________

☐ Responsible Party

Address: ________ Address 2: ________

City, State, Zip: ________

Home Phone: ________ Work Phone: ________ Ext: ______ Cell Phone: ________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ________ Soc. Sec. ________ Drivers Lic.: ________

Section 2:

Student Status: ☐ Full Time ☐ Part Time

Pref. Pharmacy: ________

Pref. Hyg.: ________

Section 3:

Referred By: ________

Emergency Contact: ________

Emergency Contact #: ________

Responsible Party (if someone other than the patient)

First Name: ________ Last Name: ________ Middle Initial: ________

Preferred Name: ________

Address: ________

City, State, Zip: ________

Home Phone: ________ Work Phone: ________ Ext: ______ Cell Phone: ________

Birth Date: ________ Soc. Sec.: ________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: ________ Insured Birth Date: ________ Insurance ID: ________

Employer: ________

Address: ________

City, State, Zip: ________

Ins. Company: ________

Address: ________

City, State, Zip: ________

Electronic Agreement

- I agree that the dental practice may communicate with me electronically at the email address below.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing the dental practice any updates to my email address.
- I can withdraw my consent to electronic communication by calling: 828.277.6868.
  Email Address (PLEASE PRINT CLEARLY)

  ____

  Patient Signature:________

  Date:________