FIFTY-SEVEN 57 DENTAL PATIENT INFORMATION

Patient Full Name: **Date:**

PATIENT INFORMATION (Authorized Contact Information)

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Age: Social Security #:

Sex: M F Email:

Emergency Contact Name: Emergency Contact Phone #:

Our software allows you to use text and/or email for appointment reminders, appointment requests, and to give feedback.

(Check all that apply)

Yes, I would like to receive **TEXT MESSAGES**

Yes, I would like to receive **EMAILS**

No, I am **NOT** interested in receiving texts or emails at this time.

RESPONSIBLE PARTY (Complete if patient is a minor or someone other than the patient is responsible for payment.)

First Name: Last Name: Middle Initial:

Responsible Party's Address (if different from patient address above):

City: State: Zip:

Best Phone Number to Reach Responsible Party:

Responsible Party's Birth Date: Responsible Party's Social Security #:

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: Policy Holder's Social Security #:

Policy Holder's Birth Date: Relationship to Patient: Self Spouse Parent Other

Employer: Dental Insurance Company:

Dental Insurance ID #: Dental Insurance Group #:

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: Policy Holder's Social Security #:

Policy Holder's Birth Date: Relationship to Patient: Self Spouse Parent Other

Employer: Dental Insurance Company:

Dental Insurance ID #: Dental Insurance Group #:

OTHER

How did you hear about us?

If referred, whom may we thank?

Please sign and date this form below. Your signature below indicates that the information on this is complete and accurate to the best of your knowledge.

Signature of Patient Date

Signature of Parent/Guardian (if minor) Date