Distinctive Dentistry

Patient Information

Completion of this information in its entirety is required at time of visit.

A. Personal Information:

Name: _____

Social Security Number: _____-_____-_____ M / F DOB: _____/_____/_____

Home Address: _____ _____ _____ _____

Home Phone: (_____) - _____ - _____ Cell: (_____) - _____ - _____

Email Address: _____@_____.____

Employer: _____ Phone: (_____) - _____ - _____

Employer Address: _____ _____ _____ _____

Spouse Name: _____

Spouse Social Security Number: _____-_____-_____ DOB: _____/_____/_____

Spouse Employer: _____ Phone: (_____) - _____ - _____

Spouse Employer Address: _____ _____ _____ _____

Whom may we thank for referring you? _____

B. If someone other than the PATIENT is responsible for payment, complete the following:

Name: _____

Relationship to patient: (Please Circle) Spouse Guardian Other

Home Address: _____ _____ _____ _____

Social Security Number: _____-_____-_____

Home Phone: (_____) - _____ - _____ Cell: (_____) - _____ - _____

C. In case of EMERGENCY

Relative to contact (other than spouse): _____ Phone: (_____) - _____ - _____

Other person to contact (not relative): _____Phone: (_____) - _____ - _____

D. How do you intend to pay? (Please Circle) Cash Check Credit Card Insurance Other

Primary Insurance Co. _____ Phone: (_____) - _____ - _____

Name of Insured Policy Holder: _____

Social Security Number: _____-_____-_____ ID# _____ Group # _____

Address: _____ _____ _____ _____

Secondary Insurance Co. _____ Phone: (_____) - _____ - _____

Name of Insured Policy Holder: _____

Social Security Number: _____-_____-_____ ID# _____ Group # _____

Address: _____ _____ _____ _____

E. Reason for Visit: (Please Circle) Routine Injury Job Related Injury Auto Accident

Date of injury or onset of problem _____/_____/_____

Worker's Compensation Carrier: _____ Phone: (_____) - _____ - _____

Explain symptoms: _____

F. Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature _____ Date_____