

PATIENT INFORMATION

Date _____

→ PLEASE FILL OUT ALL PERTINENT INFORMATION FOR THE PATIENT ←

Legal Name: First: _____ M.I. _____ Last: _____

Prefers to go by: _____ **Patient's SS #** _____

Name & Relationship of Guardian _____ **Birth Date** _____

Driver's License # _____ **Patient's last dental visit** _____

Home Address: _____
Street City State Zip

Home phone: (____) _____ **Work:** (____) _____

Cell: (____) _____ **Email address:** _____

How would you prefer we **contact** you? Email _____ Cell _____ Home _____ Work _____

Employer: _____ **Occupation:** _____

Work Address: _____ **Yrs. Employed:** _____

Spouses Name: First: _____ M.I.: _____ Last: _____

Spouse's Employer: _____ **Occupation:** _____

Yrs. Employed: _____ **Spouse's SS#:** _____ **Birth Date:** _____

Work Phone: (____) _____ **Cell:** (____) _____

Whom may we thank for referring you to our office? _____

Did you make your appointment after visiting our website (www.rhoadesdds.com?) _____

Did you notice our sign? _____ Was our location a factor in choosing us? _____

Have any other family members been to this office? _____ Whom? _____

INSURANCE INFORMATION

Insured's Name _____ **Group #:** _____

Insured ID: _____ **Insured SS #:** _____

Insured's Date of Birth _____ **Do you have dual coverage?** Yes _____ No _____

EMERGENCY INFORMATION

Emergency Contact Person: _____

Home Phone: (____) _____ **Alternate Phone:** (____) _____

Relationship to Patient: _____

Address: _____
Street City State ZIP

I understand I am **responsible for my account**. If I have dental insurance the claims will be filed for me, and I will be responsible for any remaining balance. I also understand this office values my time and will make every effort to honor my appointment times. Likewise if I fail to keep my appointments, without **24 hours notice**, I understand I will be charged for those times and/or dismissed from the practice. If you are the parent of a minor child and are bringing them for treatment in this office, you are responsible for the child's balance.

Signature _____ **Relationship to Patient:** _____

