ACQUAINTANCE INFORMATION

Patient Information

Date _____

Patient's Name _____ Mr./Mrs./Miss/Ms. (please circle one)
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 _____

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

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

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