PENINSULA DENTAL CARE

WELCOME

Today's Date _____/_____/_____

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ *Social Sec.#* _____-____-_____ *Birth date* ____/____/_____

*Home Phone*_____ *Work Phone*_____ *Cell Phone*_____

*Email*_____

Address _____ *Apt* _____ *City* _____ *State* _____ *Zip Code*_____

Choose Appropriate Social Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* ☐ *Other:*_____

☐ *Minor → If patient is a student, Name of School / College* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Whom May We Thank for Referring You? _____

Contact name in Case of Emergency _____ *Phone* _____

Responsible Party

Name of Person responsible for this Account _____ *Birth date* ____/____/_____

Relationship to patient _____ *Home Phone* _____ *Cell Phone*_____

Address _____ *Apt* _____ *City* _____ *State* _____ *Zip Code*_____

Driver's License/ State # _____ *Social Security #* _____-_____-_____

Employer _____ ***Work Phone*** _____

Is this Person Currently a Patient in our Office? ____ *Yes* ____ *No*

Dental Benefit Information

Name of Insured _____ *Relationship to Patient* _____

Birth date _____/_____/_____ *Social Security #* _____-_____-_____ *Member Id #*_____

Name of Employer _____ *Work Phone* _____ *Date Employed* ____/____/_____

Address of Employer _____ *City* _____ *State* ____ *Zip Code* _____

Insurance Company _____ *Group #* _____

Insurance Co. Address _____ *City* _____ *State* ____ *Zip Code* _____*Phone*_____