ADULT DENTISTRY of BALLANTYNE

Patient Information

Patient Name: ______________________________ Date:_____/_____/_______
Last First MI

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Preferred Name:____________________

☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Male ☐ Female

Social Security #: ____________________ Birth Date:____________________

Phone (Home): ______________ (Work): ______________ Ext:______ (Cell):______________

Address: ____
Street Apartment #

____
City State Zip Code

Email Address:______________________________

Emergency Contact Person:____________________ Emergency Contact Phone:______________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Dental Office

☐ Yellow Pages ☐ Newspaper ☐ Postcard ☐ Other mailing ☐ Other________________

Name of person or office referring you to our practice:______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext:______ (Cell): ______________

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ____________________

Address: ____
Street City State Zip Code

Insurance Information

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ SS or ID #: ______________ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Minor ☐ Other________________

Dental Insurance Company:____________________ Dental Insurance Phone: ______________

Dental Insurace Co. Claims Address:____

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