

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
 Physician Internet Search 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 Same as above
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 Insurance Co. Claims Address: _____
