NAME:

Last *First* *M.I.* *Preferred*

ADDRESS:

Street or PO Box *City* *State* *Zip Code*

Single Married Child	***BIRTH DATE** (mm/dd/yyyy) :*	***Social Security #***	**PHONE NUMBERS:** *HOME:* *CELL:* *WORK:*
	E-mail:		

Patient Employer	*Employer Phone #*

PERSON RESPONSIBLE FOR BILL	*RELATIONSHIP TO PATIENT*	*SSN:* *DOB (mm/dd/yyyy):*

ADDRESS & PHONE # FOR RESPONSIBLE PARTY (if different from patient)

INSURANCE INFORMATION

PRIMARY *Policy Holder's Full Name*		*Relationship to Patient*
Policy Holder Social Security #	*DOB (mm/dd/yyyy):*	*Policy Holder Address (if different than patient)*
Insurance Company Name		
Policy Holder's Employer		*Employer Phone #*

SECONDARY *Policy Holder's Full Name*		*Relationship to Patient*
Policy Holder Social Security #	*DOB (mm/dd/yyyy):*	*Policy Holder Address (if different than patient)*
Insurance Company Name		
Policy Holder's Employer		*Employer Phone #*

GETTING TO KNOW YOU

1. Is another member of your immediate family (living at the same address) a patient in our practice? If yes, whom?

2. Whom may we thank for referring you?

3. Person to contact for emergency: *Phone Number:*

HIPAA PRIVACY CONTACTS

I am providing written permission for Centerburg Dental Care to speak to, or leave messages at, any of the following numbers regarding my dental appointments and/or treatment.:

Name:	*Name:*
Phone #:	*Phone #:*
Relation:	*Relation:*

Signature of Responsible Party | Relationship | Date