BeGentle Dentistry

Patient Information

Name (Last, First, Middle Initial): _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ email: _____

How do you prefer to be contacted (circle all that apply): home phone cell phone text email other :_____

Sex: **M F** Age: _____ Birthdate: _____ Circle one: **SINGLE MARRIED WIDOWED SEPARATED DIVORCED**

Patient employed by: _____ Occupation: _____

School patient attends: _____

Whom may we thank for referring you? _____

Emergency contact: _____ Relationship: _____

Phone number: _____

Emergency contact: _____ Relationship: _____

Phone number: _____

Insurance

Person Responsible for Account _____

Relation to Patient _____ Birthdate: _____ SS# _____

Address (if different from patient) _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Person Responsible employed by: _____ Occupation: _____

Insurance company: _____ Phone: _____

Group #: _____ ID#: _____

Claims Mailing address: _____

Is patient covered by additional insurance? **YES NO**

PLEASE BRING INSURANCE CARD TO FIRST APPOINTMENT!

OVER→