ACQUAINTANCE INFORMATION

(Please complete all information in its entirety)

Patient Information

Appointment Date: _____

Patient Name _____ Today's Date _____
First Middle Initial Last

How do you wish to be addressed? _____ Social Security Number _____

Address: Street_____ Apt _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone Number _____

Employer _____ Work Phone Number _____

Work Address _____ Date of Birth _____

Occupation _____ Number of Years Employed _____

Marital Status _____

Spouse's/Parent's Name _____ Spouse's/Parent's Date of Birth _____

Spouse's/Parent's Employer _____ Spouse's/Parent's Occupation _____

Spouse's/Parent's Work Address _____

Whom may we thank for referring you to our office? _____

If not your general dentist, who is your general dentist? _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I have answered these questions to the best of my knowledge.

Signature: _____ Date: _____

Revised 6/03