Welcome

Patterson Family Dentistry, P.C.

(Please Print)

PATIENT INFORMATION

Name_____Nickname_____
(Last) (First) (M.I.)
Address_____City_____State_____Zip_____
Home Phone ( )_____Work Phone ( )_____Cell Phone ( )_____
SS#_____Employer_____Occupation_____
Full Time Student ☐Y ☐N School_____City/State_____
Birthdate_____ Sex ☐M ☐F ☐Married ☐Divorced ☐Widowed ☐Single ☐Minor
Spouse's Name_____Birthdate_____SS#_____
Mother's Name (if minor)_____Birthdate_____SS#_____
Father's Name (if minor)_____Birthdate_____SS#_____
Whom may we thank for referring you?_____
Person to contact in case of an emergency_____Phone ( )_____

RESPONSIBLE PARTY (IF NOT PATIENT)

Name_____Birthdate_____Sex ☐M ☐F
Address_____City_____State_____Zip_____
Home Phone ( )_____Work Phone ( )_____Cell Phone ( )_____
SS#_____Employer_____Occupation_____

DENTAL INSURANCE

Primary ***Dental Insurance*** *Coverage* (Please present all dental insurance I.D. cards)
Subscriber's Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____
SS#_____Birthdate_____Home Phone ( )_____

Insurance Company Name/Address_____
_____

Group#_____Insured I.D._____Work Phone ( )_____
Employer_____Occupation_____

Secondary ***Dental Insurance*** *Coverage* (Please present all dental insurance I.D. cards)
Subscriber's Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____
SS#_____Birthdate_____Home Phone ( )_____

Insurance Company Name/Address_____
_____

Group#_____Insured I.D._____Work Phone ( )_____
Employer_____Occupation_____