Patient Information

Date _____

Patient Name _____ Date of Birth _____ Age _____ ○ Male ○ Female

Marital Status _____ Name of Spouse _____

If a child, parents or guardian name _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Social Security _____ Driver's License # (Parents, if child) _____

Send Statement to Above Address? _____ Email Address _____

Employment Information

Patient or Parent Employed By _____ Occupation _____

Business Address _____

Work Phone _____ May we call you at work? _____

Spouse Employed By _____ Occupation _____

Business Address _____

Work Phone _____ May we call them at work? _____

Dental Insurance Information

Name of Primary Insurance Company _____ Group Number _____

Insurance Company Address _____ Telephone _____

Name of Policy Holder _____ Policy Holder Social Security # _____

Name of Secondary Insurance Company _____

General Information

In case of emergency who should be notified? _____ Telephone # _____

Were you referred to us by one of our patients? If so, whom may we thank? _____

If no, how did you find us? _____

What aspects of dentistry interest you most? _____

☐ *I attest to the best of my knowledge the information provided above is accurate and complete. Any changes in health status or medications will be reported to the doctor at the next visit.*

METHOD OF PAYMENT: ○ Cash ○ Check ○ Master Card ○ Visa ○ Care Credit

Payment Policy: Payment is requested at the times services are rendered. Unless other arrangements are made. Assignment accepted from insurance companies will be accepted with the understanding that the patient pay their portion as the work is performed unless other arrangements are made. I/ We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements and in the event of default to pay reasonable collection charges and/or attorney fees.

Patient Signature _____ *Guardian Signature* _____

SHARYLAND FAMILY DENTISTRY, P.C.

PRINT SUBMIT