Thomas Dental Care

Patient Information

Name____

Address____

City, State, Zip____

Home phone ____

Work phone____

Cell phone ____

May we text you regarding appointments? Yes ☐ No ☐

Email address____

Social Security #____

Drivers License # ____

Date of birth ____

Marital Status________ Gender__________

Person to contact in case of emergency:

___________________________________ph#________________

Person responsible for account:_________________________________

Relationship to patient _________________________________

Phone number____

Previous dentist ____

Phone number ____

Last visit ____

Physician's name____

Last visit___________________________Phone________________

Employer____

Position____

Information about your spouse or parent

Name____

Business/Home phone ____

The above information is accurate to the best of my knowledge: Signature____________________________Today's date____________

Whom may we thank for referring you? ____

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

____

Patient Signature Date

I acknowledge I have read a copy of the Dental Materials Fact Sheet dated June 2004 and was given one if requested.

____

Patient Signature Date

If applicable fill out completely

Insurance company information

Primary Insurance

Name of insured____

Date of birth ____

Social Security #.____

Insurance carrier ____

Employer____

Group plan #____

Secondary Insurance

Name of insured____

Date of birth ____

Social Security #.____

Insurance carrier ____

Employer ____

Group plan #____

I AUTHORIZE THIS OFFICE TO COLLECT DIRECTLY FROM MY INSURANCE COMPANY, THE AMOUNT OF MONEY OWED BY THEM FOR DENTAL SERVICES.

Signature:____

(rev.8-2016)