

Date: _____

Chart Number: _____

Confidential Patient Information
Please Print Clearly

I. Patient Information:

Name: _____ **Marital Status:** **M** **D** **S** **W**
Birthdate: _____ **Gender:** **M** **F** **Driver's License #:** _____
Address: _____ **Apt. #** _____ **City & State:** _____ **Zip Code:** _____
Home #: _____ **Work #:** _____ **Cell #:** _____
E-Mail Address: _____

II. Responsible Party:

Name: _____ **Relationship to Patient:** _____
Social Security #: _____ **Driver's License #:** _____
Name of Employer: _____ **Employer's Phone #:** _____
Occupation: _____ **Union/Local:** _____
Name of Insurance Coverage: _____ **Insurance Phone #:** _____
Group/Policy #: _____

III. Secondary Insurance Coverage. (Complete this Section if Patient is Covered by Another Insurance Company).

Name: _____ **Relationship to Patient:** _____
Social Security #: _____ **Driver's License #:** _____
Name of Employer: _____ **Employer's Phone #:** _____
Occupation: _____ **Union/Local:** _____
Name of Insurance Coverage: _____ **Insurance Phone #:** _____
Group/Policy #: _____

IV. General Information for your File:

Who Can We Thank for Referring You? _____
Emergency Contact (Friend or Relative not Living with You). _____ **Phone #:** _____

Directly Billing Your Insurance:

I hereby authorize payment directly to Parkside Dental of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize dental care and release of any information relating to dental claims.

Signature: _____