PATIENT INFORMATION

PATIENT NAME_____

PATIENT ADDRESS_____
ADDRESS CITY STATE ZIP CODE

IF CHILD, LIST PARENTS_____

PATIENT DATE OF BIRTH _____ **PATIENT SOCIAL SECURITY #**

PATIENT PHONE #_____
(STAR (*) PREFERRED # TO CALL HOME WORK CELL

OCCUPATION_____**SPOUSE'S NAME**

IF YOU HAVE CHILDREN, DO THEY PRIMARILY DRINK LINCOLN CITY TAP WATER?_____

HOW DID YOU LEARN ABOUT OUR OFFICE?_____

IF YOU WERE REFERRED, BY WHOM?_____

FOR WHAT PURPOSE IS YOUR APPOINTMENT TODAY?_____

DENTAL INSURANCE INFORMATION

NAME OF INSURED_____

INSURED ADDRESS_____
ADDRESS CITY STATE ZIP CODE

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

EMPLOYER_____

EMPLOYER ADDRESS_____
ADDRESS CITY STATE ZIP CODE

INSURANCE COMPANY_____

INSURANCE ADDRESS_____
ADDRESS CITY STATE ZIP CODE

GROUP NUMBER _____ **RELATIONSHIP TO INSURED)CIRCLE ONE)**
SELF SPOUSE CHILD STEPCHILD OTHER

IF PATIENT IS A STUDENT, LIST SCHOOL ATTENDING:

_____
NAME ADDRESS CITY STATE ZIP CODE

I HAVE READ THE OFFICE FINANCIAL POLICY AND A COPY IS AVAILABLE UPON REQUEST.

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