

PATIENT RECORD

DENTIST: DR. DON _____ DR. KATE _____

PATIENT NAME _____
(LAST) (FIRST) (MI) (NICKNAME)

ADDRESS _____ APT # _____

CITY/STATE _____ ZIP _____

HOME PHONE (____) _____ - _____ PATIENT'S BIRTHDATE ____/____/____

SOC SEC# _____ - _____ - _____ SEX _____ HEIGHT _____ WEIGHT _____

MARITAL STATUS: SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____

PARENT'S NAME _____
(If child) (LAST) (FIRST) (MI)

OCCUPATION _____ BUSINESS PHONE (____) _____ - _____
(If child, parent/guardian's information)

EMPLOYER'S ADDRESS _____
(Include city, state, and zip)

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

ADDRESS _____ BUSINESS PHONE (____) _____ - _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE (____) _____ - _____

REFERRED TO US BY _____

PERSON RESPONSIBLE FOR PAYMENT _____ PHONE (____) _____ - _____

ADDRESS _____

(FIRST VISIT TO BE PAID IN CASH OR CREDIT CARD UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE)

*******DENTAL INSURANCE INFORMATION*******

COMPANY AND ADDRESS _____

MEMBER'S NAME _____ SOC. SEC# _____ - _____ - _____

DATE OF BIRTH ____/____/____ GROUP/POLICY# _____

HOME ADDRESS OF MEMBER _____

Nelson Family Dentistry will be more than happy to file your insurance claim for you. Please be advised that it is your (the patients) responsibility to contact the insurance company and verify coverage with your specific dentist. Any claim not paid by insurance will be the patient's (or guardian's) responsibility.

Patient or Guardian's Signature _____ Date ____/____/____