Patient Record

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

EMAIL ADDRESS ____

ADDRESS______________________________________APT# __________

CITY/STATE____ZIP _______

HOME PHONE (_______)_______-_________ PATIENT'S BIRTHDATE_______/_______/_________

CELL PHONE (_______)_______-_________

SOC SEC#_______-______-_________ SEX_____HEIGHT__________WEIGHT__________

MARITAL STATUS_______SINGLE________MARRIED________WIDOWED________DIVORCED________

PARENT'S NAME ____
(If Child) (LAST) (FIRST) (MI)

EMPLOYER______________________________BUSINESS PHONE (_______)_______-_________
(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#____________MEMBERID#____________

HOME ADDRESS OF MEMBER ____

Nielson Family Dentistry will be more than happy to file your insurance claim for you. Please be advised that 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_______/_______/_________