FRONTIER VILLAGE DENTAL CARE

Cosmetic and Family Dentistry

PATIENT INFORMATION FORM

Patient Last Name _____First _____Middle Initial _____

Name of Guardian if patient is a minor: _____

Check one __Dr. __ Mr. __Mrs. __ Ms. I prefer to be called _____

Marital status __single __ married __ child __ other Gender __ male __ female

Date of Birth _____ SS#_____

Address _____ City _____ State _____ Zip _____

Home phone #_____ Work #_____ Cell# _____

Email _____

Spouse's Name _____ Phone # _____

Other family members seen by us_____

Employer _____ Occupation _____ # of yrs _____

Employer Address_____ City _____ State ____ Zip _____

Who will be responsible for your account? _____ (PAYMENT EXPECTED AT TIME OF SERVICE)

Responsible Party Name _____ Relation _____

Responsible Party Address_____ City _____ State ____ Zip _____

Primary Insurance Company _____ Employer _____

Phone # _____ ID # _____ Group# _____

Who is the insured member in you family? __ Yourself __ Spouse __ Other

Policy Holder Name _____ Date of Birth _____ SS#_____

Policy Holder Employer _____ Work# _____

Has the insured had previous dental care under this plan? YES NO

Secondary Insurance Company _____ Employer _____

Phone # _____ ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____ SS#_____

Policy Holder Employer _____ Work# _____

Emergency Contact Name _____ Relation _____ Phone # _____

Whom may we thank for referring you: _____