

## PATIENT INFORMATION

Miss  Ms.  Mrs.  Mr.  Dr.  Sr.  Jr. Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I prefer to receive phone calls at:  Home  Business  Cell

Email Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  M  F

If Student, Name of School/College: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Patient or Parent/Guardian Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_

How did you hear about our office?  Online  Newspaper  Patient  Phonebook Ad

If referred by a patient, what is the patient's name? \_\_\_\_\_

### Responsible Party:

Name of Person Responsible for the Account: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Is this Person Currently a Patient at Our Office?  Y  N

### Insurance Information:

Name of Insurance Subscriber: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Insurance Identification #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

### Additional Insurance:

Name of Insurance Subscriber: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Insurance Identification #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_



*We Keep Families Smiling*

**CORNING DENTAL ASSOCIATES** RLLP