Augusta Dental
Office, P.C.

Patient Information

Please Print

Account Number: _____

Circle One: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____ Last: _____ Jr/Sr: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email Address: _____ May we contact you by Email? (circle) **Yes No**

Patient Social Security Number: _____ Patient Date of Birth: _____ Sex:(circle) **M F**

Emergency Contact: _____ Phone: _____

How did you hear about us ?

☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Referral ☐ Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No**

Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber	☐Self ☐Spouse ☐Child ☐Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present card to receptionist to be photocopied			

Payment Options

We understand that affordability is an important consideration in getting the dental treatment you need and deserve. We offer a variety of payment options so that your treatment is within reach. If you think you may be interested in one of our payment programs—and to save you time later on—just complete the section below. We'll do the rest.

General Information			**Employer Information**	
Drivers License Number:	State:	Exp. Date:	Employer Name	
Residence Status: ☐ Own	☐ Rent	☐ Live with others	Employer Phone	
Income			Personal Reference	
Source of Income:	☐ Employed	☐ Self-Employed ☐	Personal Reference Phone #	
☐ Unemployed	☐ None	☐ Social Security ☐	Nearest Relative Phone #	
☐ Disability ☐	☐ Investment	☐ Other:		
☐ Monthly	☐ Hourly	☐ Yearly		
Gross $Amount:	Net $Amount:			