Tom Anderson, D.D.S

Patient Information

Date _____ Email Address _____

Name _____ Title _____
Last *First* *MI* *Mr. Mrs. Ms. Dr.*

I prefer to be called _____ ☐ Male ☐ Female

Birthdate _____ / _____ / _____ Age _____ SSN _____

Address _____
Street *Apt.* *City* *State* *Zip*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____ Cell _____

Work Phone _____ Ext. _____ Other Phone _____

Employer _____

Employer Address _____
Street *City* *State* *Zip*

Length of Employment _____ Occupation _____

Best time to call you ☐ am ☐ pm Referred by _____

Others in your family seen by us _____

Previous / Current Dentist _____ Last Visit Date _____
circle one

Spouse/Partner Information

Name _____ Employer _____

Occupation _____ SSN _____

Work Phone _____ Birthdate _____/ _____/ _____

Person Responsible for the Account

☐ Myself ☐ Spouse/Partner ☐ Other listed below

Name _____ Employer _____

Driver's License # _____ Relationship _____

Work Phone _____ Home or Cell Phone _____

Social Security # _____

Billing Address _____

_____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Work Phone _____ Home/Cell _____

Primary Insurance

Dental Insurance? ☐ **Yes** ☐ **No**

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group Number (Plan, Local or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthdate_____ / _____/ _____ Insured's SSN _____

Insured's Employer _____

Employer's Address _____

_____

Secondary Insurance

Dental Insurance? ☐ **Yes** ☐ **No**

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group Number (Plan, Local or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthdate_____ / _____/ _____ Insured's SSN _____

Insured's Employer _____

Employer's Address _____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

_____ _____

Signature *Date*

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ _____

Signature *Date*