Patient Information

A B C

Date _____

Patient's Name _____ (Last) (First) (Middle)

Address _____ (Street) (City) (State) (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

Cell Phone _____ Email _____

How did you hear about Valley Dental Care? _____

Responsible Party Information

Name _____ (Last) (First) (Middle) (Marital Status)

Mailing Address _____ (Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security # _____ Birth Date _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last) (First) (Middle)

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birth Date _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I hereby consent to dental treatment by Valley Dental Care.

Signature (Parent's signature if minor) _____

_____

CONFIDENTIAL (for record and pretreatment evaluation)