PIERCE DENTAL OFFICE, PC

In order to better serve our patients, we need to ensure that our records are complete.
Thank you for providing the following current information:

PATIENT INFORMATION

PATIENT'S NAME:_____Preferred Name: _____
□ Male □ Female □ Married □ Single □ Divorced □ Separated □ Widowed
DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____
ADDRESS:_____
CITY, STATE, ZIP_____
TELEPHONE:_____
CELL PHONE NUMBER:_____ □ Able to receive text messages
WORK PHONE NUMBER:_____□ Unable to accept calls at work.
E-MAIL ADDRESS:_____

PREFERRED CONTACT (circle one): Home Cell E-Mail Work Other_____

EMPLOYER:_____ PHONE NUMBER:_____
ADDRESS:_____

PRIMARY PHYSICIAN_____PHONE NUMBER_____
OTHER PHYSICIAN_____PHONE NUMBER_____
OTHER PHYSICIAN_____PHONE NUMBER_____

RESPONSIBLE PARTY INFORMATION (if other than Patient)

RESPONSIBLE PARTY:_____ RELATIONSHIP:_____
DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____
ADDRESS:_____
CITY, STATE, ZIP_____
TELEPHONE:_____CELL PHONE NUMBER:_____
WORK PHONE NUMBER:_____□ Unable to accept calls at work.
E-MAIL ADDRESS:_____

PREFERRED CONTACT (circle one): Home Cell E-Mail Work Other_____

EMPLOYER:_____ PHONE NUMBER:_____
ADDRESS:_____

FAMILY CONTACT INFORMATION (if other than Patient or Responsible Party)

SPOUSE'S NAME:_____
DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____
ADDRESS:_____
CITY, STATE, ZIP_____
TELEPHONE:_____CELL PHONE NUMBER:_____
WORK PHONE NUMBER:_____□ Unable to accept calls at work.
E-MAIL ADDRESS:_____

PREFERRED CONTACT (circle one): Home Cell E-Mail Work Other_____

EMPLOYER:_____ PHONE NUMBER:_____
ADDRESS:_____

PLEASE COMPLETE OTHER SIDE

INSURANCE INFORMATION – PLEASE PROVIDE A CURRENT COPY OF INSURANCE CARD

PRIMARY DENTAL INSURANCE:_____
ADDRESS:_____
SUBSCRIBER:_____
EMPLOYER NAME/GROUP NUMBER_____

SECONDARY DENTAL INSURANCE:_____
ADDRESS:_____
SUBSCRIBER:_____
EMPLOYER NAME/GROUP NUMBER_____

EMERGENCY CONTACT (other than someone who lives with you)

NAME:_____RELATIONSHIP:_____
ADDRESS:_____
PHONE NUMBER:_____

IF PATIENT IS A MINOR

MOTHER'S NAME:_____FATHER'S NAME:_____
GUARDIAN'S NAME:_____PATIENT RESIDES WITH:_____

MINOR PATIENT WILL BE ACCOMPANIED BY (circle one): PARENT SELF OTHER

IF SOMEONE OTHER THAN A PARENT OR LEGAL GUARDIAN WILL BE PRESENTING A MINOR FOR TREATMENT, PLEASE PROVIDE THEIR CONTACT INFORMATION:

NAME:_____RELATIONSHIP:_____
ADDRESS:_____
TELEPHONE:_____CELL PHONE NUMBER:_____
WORK PHONE NUMBER:_____□ Unable to accept calls at work.
E-MAIL ADDRESS:_____

*If a minor patient will arrive for treatment **unaccompanied or be presented for treatment by someone other than the parent or legal guardian**, a "CONSENT TO TREAT" form must be completed or we may be unable to provide care.

PATIENT PREFERENCES

- □ I prefer AM appointments.
- □ I prefer PM appointments.
- □ I am flexible on appointment times.
- □ I can come on short notice for my appointments.

PREFERRED PHARMACY:_____

Who may we thank for inviting you to our office?_____

SIGNATURE_____DATE_____

□ HIPAA NOTICE Reviewed by _____