HADA family dental

Thank you for selecting our dental healthcare team! We Will Strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

SS#/SIN _____

PATIENT INFORMAITION (CONFIDENTIAL) Date _____

Name | Home Phone

Nickname | Birthdate

Address | City | State | Zip

Email | Cell Phone

Check Appropriate Box: ○ Minor ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced

If Student, Name of School/College: | City/State:

Parent/Guardian's Employer | Work Phone

Business Address | City/State: | Zip

Parent/Guardian's Name

Whom may we thank for referring you?

Person to contact in case of emergency

RESPONSIBLE PARTY

Name of Person Responsible for this Account | Relationship to Patient

Address | Home Phone

Email | Cell Phone

Driver's License# | Birthdate

Employer | Work Phone | SS#/SIN

Is this person currently a patient in our office?

INSURANCE INFORMATION

Name of Insured | Relationship to Patient

Birthdate | SS#/SIN | Date Employed

Name of Employer | Work Phone #

Address of Employer | City/State | Zip

Insurance Company | Group # | ID #

Ins. Co. Address | City/State | Zip

DO YOU HAVE ADDITIONAL INSURANCE? ○ Yes ○ No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured | Relationship to Patient

Birthdate | SS#/SIN | Date Employed

Name of Employer | Work Phone #

Address of Employer | City/State | Zip

Insurance Company | Group # | ID #

Ins. Co. Address | City/State | Zip