SILVER STATE DENTAL

CONFIDENTIAL PATIENT INFORMATION

Please Print Clearly

I. Patient Information

Name:_____Prefer Name:_____

Birthday:_____ M / F Marital Status: S M D Social Security #:_____

Address:_____City & State:_____Zip Code:_____

Home Phone:_____Cell Phone: _____

Driver License#:_____email: _____

Employer's Name:_____Phone Number :(____)_____

Address:_____City&State:_____Zip Code:_____

II. Responsible Party or Primary Insurance Information (if applicable)

Name:_____Relationship to Patient:_____

Social Security #:_____DOB:_____Occupation:_____

Name of Employer:_____Phone#:_____

Address:_____City/State:_____Zip Code:_____

Insurance Company: _____Phone#:_____

Union/Local:_____Group Number:_____

III. Second Insurance Information (if applicable)

Subscriber:_____Relationship to Patient:_____

Social Security #:_____DOB:_____Occupation:_____

Name of Employer: _____Phone#:_____

Address:_____City/State:_____Zip Code:_____

Insurance Company:_____Phone#:_____

Union/Local: _____Group Number:_____

IV. Getting to Know You and Your Family

How did you hear about Silver State Dental?_____Last dental x-rays taken?_____

When was last dental visit?_____What treatment was performed?_____

Please list all immediate family members:

Name:	Relationship:	Birthdates	Date of last dental visit

V. Emergency Contact (Friend or relative not living with you)

Name:_____Telephone (____)_____

I hereby acknowledge I have read, understand, and agree to the terms stated under the Financial & Health Information Policy of Silver State Dental.

Patient / Parent /Guardian Signature_____**Date**_____

Print Name if Parent /Guardian_____