Spring View
DENTAL

CONFIDENTIAL PATIENT INFORMATION

DATE_____

(PLEASE PRINT)

CELL PHONE _____ HOME PHONE _____

NAME _____ BIRTHDATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER_____ WORK PHONE_____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY_____ STATE_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ CURRENTLY A PATIENT ☐ YES ☐ NO

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ CELL PHONE _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY / ID NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER_____ CITY _____ STATE_____ ZIP_____

INSURANCE COMPANY_____ GROUP #_____ UNION OR LOCAL #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE_____ SOCIAL SECURITY / ID NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER_____ CITY_____ STATE_____ ZIP _____

INSURANCE COMPANY_____ GROUP #_____ UNION OR LOCAL # _____

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SIGNATURE OF PATIENT OR PARENT IF MINOR