

Welcome to Pacific Springs Dental

Patient Information (Confidential) Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Social Security Number

Check where appropriate: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

If student, name of school/college _____ City _____ State _____ Full time ___ Part time

Patient's or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you?

Person to contact in case of emergency _____ Phone _____

Responsible Party (Please fill out if different from above.)

Name of person responsible for this account _____ Relationship _____

Address _____ Home phone _____

Birthdate _____ Employer _____ Work phone _____

Social Security Number _____

Insurance Information

Name of insured _____ Relationship _____

Birthdate _____ Social Security Number _____

Name of Employer _____ Work phone _____

Insurance Company _____ Group # _____

Policy/ID # _____