First Name:_____ Last Name:_____

Wednesday, August 13, 2014

PATIENT INFORMATION

Nickname: _____ Mother's name _____ Mothers Cell Phone Number _____

Marital Status (parents) Single Married Divorced Separated Father's name: _____ Fathers Cell Phone Number _____

Patients Address: _____ Home Telephone: _____

Birth date: _____ Age: _____ Sex: _____ Parent E-mail : _____

Best way to reach you _____ Contact Number _____

School/Employer: _____ Grade/Position: _____

Names and Ages of Brothers & Sisters: _____

Interest/Sports _____

Reason For Consultation: _____

Whom May We Thank For Referring You To Us? A Dentist Another Patient A Relative Acquaintance Insurance Co. Adv.

_____

Present Dentist: _____

Date of last cleaning: _____

Emergency Contact: (other than self) Name: _____ Phone: _____ Relationship: _____

CUSTODIAL INFORMATION

Primary Responsible Party (Custodian): _____ Home Telephone: _____

Birth date: _____

Address: _____ How Long? _____

Employer/Address: _____ Work Telephone: _____

Insurance/Address: _____ Insurance Telephone: _____

Social Security Number: _____ Group Number: _____

Secondary Responsible Party: _____ Home Telephone: _____

Birthdate: _____

Address: _____ How Long? _____

Employer/Address: _____ Work Telephone: _____

Insurance/Address: _____ Insurance Telephone: _____

Social Security Number: _____ Group Number: _____

SIGNATURE:

Signature: _____ Relationship To Patient: _____ Date: _____

My signature on this line grants my permission for Dr. Elfman to accept assignment of insurance benefits on my account, where applicable