

**PATIENT INFORMATION**

Dr. Mr. Mrs. \_\_\_\_\_  Female  Male

Ms. Miss Rev. \_\_\_\_\_ *Last* *First* *Middle*

Address \_\_\_\_\_ **Marital Status**  Single  Married  Divorced  Widow

City, St, Zip \_\_\_\_\_ Home # \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Drivers Lic# \_\_\_\_\_

Home  Work E-mail: \_\_\_\_\_ May we send e-mails? \_\_\_\_\_

**Employer** \_\_\_\_\_ Business # \_\_\_\_\_

Employer Address \_\_\_\_\_ Extension \_\_\_\_\_

City, St, Zip \_\_\_\_\_ Cell # \_\_\_\_\_

**Spouse Name** \_\_\_\_\_ SS# \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Address \_\_\_\_\_ Business # \_\_\_\_\_

City, St, Zip \_\_\_\_\_ Extension \_\_\_\_\_

**Children's Names** \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

**Nearest Relative Not Living with You** \_\_\_\_\_ **Emergency Contact Name** \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone# \_\_\_\_\_

Mailing Address \_\_\_\_\_ Emergency Contact Home # \_\_\_\_\_

City, St, Zip \_\_\_\_\_ Emergency Contact Work # \_\_\_\_\_

**Is patient a college student?**  Yes  No Mother's Work # \_\_\_\_\_

School \_\_\_\_\_ Graduation Year \_\_\_\_\_ Father's Work # \_\_\_\_\_

**Preferred Day/Time for Appointment:** Day(s) \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

**RESPONSIBLE PARTY**  See Information Above

Subscriber's Name \_\_\_\_\_

Subscriber's Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Home # \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Business # \_\_\_\_\_ Extension \_\_\_\_\_

**DENTAL BENEFIT PLAN CARRIER**

Carrier Name \_\_\_\_\_

Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Ext. \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Plan # \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

Does patient have other dental coverage?  Yes  No

If yes, name of carrier \_\_\_\_\_

Do all dependents on Dental Associates' account have above

coverage?  Yes  No

I hereby authorize Dental Associates of Delaware to verify and obtain all necessary dental record, benefit, financial and other information related to my care. I also agree to pay any and all finance charges where applicable.

*Patient/Guardian Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

OFFICE USE ONLY

DAD Patient Account # \_\_\_\_\_ Coordinator's Initials \_\_\_\_\_  New Patient

Appointment Date/Time \_\_\_\_\_ Response needed by \_\_\_\_\_  Updated

*Coordinators* -- Please make a COPY of INSURANCE CARD(s) and attach to this sheet  EMERGENCY