******Please Turn Off Your Cell Phone******

Kelly B. Deines, DDS
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General Dentistry

Confidential Patient Information

Date_____

Patient's Name_____
(Last) (First) (Initial) (Nickname)

Soc. Sec. #_____ Date of Birth_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address _____
Apt._____

City _____State_____ Zip_____

Home Phone _____ Cell_____

Work_____ EMail_____

I prefer to be contacted by: ____Home ____ Cell ____Work ____E-Mail

Employer_____

Referred by_____

Emergency Contact _____ Phone_____

Person responsible for paying the account*_____

Address_____

Phone#_____Relationship_____SS#_____

Is the patient currently enrolled as a full-time student? Yes ☐ No☐

School Name and Location_____ Graduation date_____

***If the patient is a minor child, the parent that accompanies the child to the office will be responsible for paying the account.**

Does the patient have Dental Insurance to help pay for the appointment today? Yes☐ No ☐

****If the patient does not have insurance, full payment is expected at the time of service. ****

(Over)

Insurance Information

We will gladly file your insurance claim as a courtesy, but any outstanding balance after 60 days will become the patient's responsibility.

Please provide front and back copy of insurance card(s) **OR** complete the requested information below.

Primary Dental Insurance Information

Dental Insurance Company Name_____

Claims mailing address_____

_____

Insurance Company phone#_____

Website_____

Name of Cardholder_____

Cardholder's SS#_____

Cardholder's date of birth_____

Cardholder's employer_____

Group #_____ ID#_____

Secondary Dental Insurance Information (if any)

Dental Insurance Company Name_____

Claims mailing address_____

_____

Insurance Company phone#_____

Website_____

Name of Cardholder_____

Cardholder's SS#_____

Cardholder's date of birth_____

Cardholder's employer_____

Group #_____ ID#_____