CENTRAL DENTAL ASSOCIATES

Patient Information

Please complete this form in ink and print your answers.
If you have any *questions, please do not hesitate to ask one of our staff.*

Name _____ Date _____
First Name MI Last Name

Address _____
City _____ State _____ Zip _____
Birthdate _____ □ Male □ Female Home Phone# (____) _____
Cell Phone# (____) _____ Work Phone# (____) _____
Where do you prefer to take calls: □ Home □ Cell □ Work
May we contact you by E-mail? □ Yes □ No E-mail Address _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor
Social Security # _____ Drivers License # _____ State _____
Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Spouse's Name _____ Workplace _____
If you are a student, name of school _____ City/State _____
How did you hear about our office? _____
Who may we thank for referring you? _____
Closest relative not living with you & their phone number _____
Emergency Contact _____ Phone# (____) _____

Responsible Party *(if patient is a minor)*

Name of person financially responsible for this account _____
Relationship to patient _____ Phone # (____) _____
Address of Employer _____
City _____ State _____ Zip _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Subscriber Birthdate _____ Subscriber Social Security # _____
Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Insurance Co. _____ Group # _____
Subscriber ID # _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Company Phone # (____) _____

Do you have additional dental insurance? □ Yes □ No If yes, Please complete the following:
Insurance Co. _____ Group # _____
Subscriber ID # _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Insurance Company Phone # (____) _____