ARLINGTON ADVANCED DENTISTRY

DEDICATED TO EXCELLENCE

Patient Information (Section A)

Today's Date _____ ☐Dr. ☐Mr. ☐Mrs. ☐Ms.

Patient Name _____ Date of Birth _____
(First) (MI) (Last)

Preferred Name _____ Marital Status ☐S ☐M ☐D ☐W

Address: _____
(Number) (Street) (Apt#) (City) (State) (Zip)

Primary Phone Number: _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone Number: _____ ☐Home ☐Cell ☐Work ☐Other_____

Email Address _____ Preferred method of contact? ☐Call ☐Text ☐Email

Employer Name _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship _____ Whom may we thank for referring you? _____

Responsible Party (Section B) *If same as above, skip to Section C*

Name _____ Date of Birth _____
(First) (Last) (MI)

Relationship to patient _____ Marital Status: ☐S ☐M ☐D ☐W

Address: _____
(Number) (Street) (Apt#) (City) (State) (Zip)

Primary Phone Number _____ ☐Home ☐Cell ☐Work ☐Other_____

Email Address _____

Dental Insurance Information (Section C)

Name of Policy Holder _____ DOB _____
(First) (Last) (MI)

Social Security Number _____ Relationship to Patient _____

Member ID Number _____ Group Number _____

Employer Name _____ Insurance Company _____

Insurance Address _____ Insurance Phone Number _____

If you carry a secondary dental plan, please provide information below:

Name of Policy Holder _____ DOB _____
(First) (Last) (MI)

Social Security Number _____ Relationship to Patient _____

Member ID Number _____ Group Number _____

Employer Name _____ Insurance Company _____

Insurance Address _____ Insurance Phone Number _____

Signature

Signing below confirms the information provided on this form is accurate and complete. Arlington Advanced Dentistry is not responsible for any errors resulting from intentional or accidental omissions made in the completion of this form.

_____ **Date** _____
(Patient, Parent, or Legal Guardian)