Hardin
Cosmetic and Family Dentistry

Date: _____

Patient Information (Confidential)

Welcome!

Name_____**Birthdate**_____
Address_____**City**_____**State**_____
Zip Code_____ **Home Phone**_____
Social Security_____ **Cell Phone**_____
Email (for confirmations) _____
Drivers License#_____
Check Appropriate: _Minor _Single _Married _Divorced _Widowed
Patient or Parent /Guardians Employer_____
Employer Phone and City_____
Spouse or Parent/Guardian Name_____
Spouse or Parent/Guardian Employer_____

Whom may we thank for referring you?_____
EMERGENCY CONTACT:_____**PHONE:**_____
RESPONSIBLE PERSON for account_____

Insurance Information

Name of Insured_____Relationship to patient_____
Date of birth_____SS/ID#_____
Name of Employer_____Work#_____
INSURANCE COMPANY_____Group#_____
InsuranceAddress/City/State_____
Do you have a deductible?_____Max benefit_____
DO YOU HAVE ANY SECONDARY INSURANCE? _____
Name of Insured for Secondary _____
INSURANCE COMPANY_____Group#_____
Date of Birth_____SS/ID#_____
Name of employer _____Phone_____