COMFORT CARE DENTAL

Taking Care of Your Family

Patient Information

Last Name _____ **First Name** _____ **M.I.**_____

Preferred Name_____ **Date of Birth** _____ **Sex**_____ **SS#** _____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work #**_____ **Cell #** _____

Email _____ **DL #**_____

Are you: __ Minor __ Single __ Married __ Divorced __ Widowed __ Separated

Patient or Parent/Guardian's Employer_____ **Occupation** _____

Employer Address _____ **City, State, Zip**_____

Whom may we thank for referring you? _____ **Relationship to this person?**_____

Person to contact in case of an emergency?_____ **Phone** _____

Responsible Party

Person responsible for this account _____ **Relationship to Pt.**_____

Address_____ **Home Phone** _____

Cell Phone _____ **Drivers License #**_____ **Date of Birth** _____

Employer_____ **Work Phone** _____

SS # _____ **Is this person currently a patient in our office?**_____

E-mail _____

For your convenience, we currently offer the following methods of payment. Please check the option you prefer:

___ Cash ___ Personal Check ___ Visa ___ Master Card ___ Discover

Insurance Information

Name of Insured_____ **Relationship to Pt.**_____

Date of Birth_____ **SS #** _____ **Date Employed** _____

Name of Employer_____ **Work Phone** _____

Address of Employer_____

Name of Insurance_____ **Group Number**_____

Insurance ID # _____ **Insurance Phone #**_____

Insurance Address _____

Please notify the front desk if you have additional insurance!

Please Continue ... ⇨