ELIZABETHTOWN
DENTAL ASSOCIATES

Patient Information

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____Work Phone_____

Cell Phone_____Birthday_____

E-mail address _____

Whom may we "Thank" for referring you to our practice: _____

(**Responsible Party**) If patient is a minor, give parent's or guardian's name:

(Father/Husband)_____

Address_____

Employer_____Occupation_____

No. Years Employed_____Birthday_____

(Mother/Wife)_____

Address_____

Employer_____Occupation_____

No. Years Employed_____Birthday_____

EMERGENCY INFORMATION

Person to contact / Relationship_____

Home_____Work_____Cell_____

Dental Insurance Information

Insured's Name_____Insured's SS#_____

Insurance Company_____Group #_____ID #_____

Insurance Company Address_____

Do you have dual (2nd) coverage? Yes_____ No _____ If Yes:

Insured's name _____ Insured's SS#_____

Insurance Co._____Group's#_____ID #_____

Insurance Co. Address_____

Insured's Employer_____

Updates (date&initial) _____ _____ _____ _____ _____