EAST TOWNE DENTAL ASSOCIATES

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME Last First M.I.		SOCIAL SECURITY NUMBER	
ADDRESS Street		DATE OF BIRTH	SEX ☐Female ☐Male
City State Zip	HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.
E-MAIL		MARITAL STATUS ☐Single ☐Divorced ☐Married ☐Widowed	

PREFERRED METHOD OF CONTACT ☐ Home ☐ Cell Phone ☐ Work Phone ☐ E-Mail

RACE ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Filipino ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other

ETHNICITY ☐ Hispanic ☐ Non-Hispanic

PREFERRED LANGUAGE

2ND/SEASONAL ADDRESS Street City State Zip

EMPLOYER	PATIENTS OCCUPATION
EMPLOYER ADDRESS Street City State Zip	
PHARMACY NAME	PHARMACY PHONE NO.

HOW DID YOU HEAR ABOUT US? ☐ Online ☐ Insurance ☐ Employer ☐ Patient/ Friend/Family Name: ☐ Physician Name:

RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.

If patient is child, please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	HOME PHONE NO.
EMPLOYER	EMPLOYER PHONE NO.
EMPLOYER ADDRESS: Street City State Zip	

INSURANCE INFORMATION

PRIMARY INSURANCE RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF INSURED	SOCIAL SECURITY NUMBER
INSURANCE NAME	DATE OF BIRTH
INSURANCE ADDRESS Street	City State Zip
EMPLOYER NAME	
EMPLOYER ADDRESS: Street City State Zip	

SECONDARY INSURANCE RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME OF INSURED	SOCIAL SECURITY NUMBER
INSURANCE NAME	DATE OF BIRTH
INSURANCE ADDRESS Street	City State Zip
EMPLOYER NAME	
EMPLOYER ADDRESS: Street City State Zip	