DENTISTRY
OF THE PINES
Advanced Dentistry with Southern Hospitality

Patient Information (Confidential)

Name: _____ **Date:** _____
First MI Last
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ @ _____ **Cell #:** _____ **Home #:** _____
SS#: _____ - _____ - _____ **D.O.B.:** _____ / _____ / _____
Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's/Guardians Employer: _____ **Work #:** _____
Business Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Spouse or Parent's/Guardians Name: _____ **Employer:** _____ **Work #:** _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency: _____ **Phone #:** _____

Responsible Party

Name of person responsible for account: _____ **Relationship to Patient:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ @ _____ **Cell #:** _____ **Home #:** _____
SS#: _____ - _____ - _____ **D.O.B.:** _____ / _____ / _____ **Driver's License #:** _____
Employer: _____ **Work #:** _____
Is this person a current patient of our practice? ☐ Yes ☐ No

Insurance Information

Name of Insured: _____ **Relationship to Patient:** _____
DOB: _____ / _____ / _____ **S.S. #:** _____ - _____ - _____ **Date Employed:** _____
Name of Employer: _____ **Union or Local #:** _____ **Work #:** _____
Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Insurance Co.: _____ **Tel. #:** _____ **Group #:** _____ **Policy/ID #:** _____
Ins. Co. Address: _____ **City:** _____ **State:** _____ **Zip:** _____
How much is your deductible? $ _____ **How much have you used: $** _____ **Max Annual Benefit: $** _____

Do you have any additional insurance? ☐ Yes ☐ No *If yes, complete below*

Name of Insured: _____ **Relationship to Patient:** _____
DOB: _____ / _____ / _____ **S.S. #:** _____ - _____ - _____ **Date Employed:** _____
Name of Employer: _____ **Union or Local #:** _____ **Work #:** _____
Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Insurance Co.: _____ **Tel. #:** _____ **Group #:** _____ **Policy/ID #:** _____
Ins. Co. Address: _____ **City:** _____ **State:** _____ **Zip:** _____
How much is your deductible? $ _____ **How much have you used: $** _____ **Max Annual Benefit: $** _____

X _____
Signature of Patient or Guardian(if minor)