

DENTISTRY AT
HICKORY FLAT

Date: _____ Name: _____

Preferred Name: _____ Male Female

Home Address: _____ City _____ State _____ Zip _____

Mailing Address: _____ City _____ State _____ Zip _____

DOB: _____ S.S. _____ Email: _____

Marital Status: _____ Spouse Name: _____

Home # _____ Cell # _____ Work # _____ Ext _____

Occupation: _____ Employer: _____

Person Responsible for account

self (only check if all info is the same as above)

Name: _____ DOB: _____ S.S. _____

Address: _____ City _____ State _____ Zip _____

Relationship to patient _____ Employer/Occupation _____

Home # _____ Cell # _____ Work # _____ Ext _____

Dental Insurance

I do not currently have dental insurance

Subscriber's Name _____ Insurance Company _____

Relationship to Patient _____ Policy/Group Number _____

Subscriber's Employer _____ Address _____

Subscriber's SS# or ID# _____ City/St/Zip _____

Subscriber's Birth Date ____/____/____ Ins. Phone# (____) _____

Emergency Contact

Name: _____ Relation: _____

Home # _____ Cell # _____ Work # _____ Ext _____

Help us get to know you

How did you hear about our office?

Sign Mailer Website Insurance Yellow Pages

Other _____ Family / Friend _____

Signature: _____
(Patient or Parent/Guardian)

Date: _____