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: _____ Date: _____

(Patient or Parent/Guardian)