NAME:

Last *First* *M.I.* *Preferred*

ADDRESS:

Street or PO Box *City* *State* *Zip Code*

Single
Married
Child

BIRTH DATE** (mm/dd/yyyy):* | ***Social Security # | **PHONE NUMBERS:**

HOME:

E-mail: | *CELL:*

WORK:

Patient Employer | *Employer Phone #*

PERSON RESPONSIBLE FOR BILL | *RELATIONSHIP TO PATIENT* | *SSN:* / *DOB (mm/dd/yyyy):*

ADDRESS & PHONE # FOR RESPONSIBLE PARTY (if different from patient)

INSURANCE INFORMATION

PRIMARY *Policy Holder's Full Name* | *Relationship to Patient*

Policy Holder Social Security # | *DOB (mm/dd/yyyy):* | *Policy Holder Address (if different than patient)*

Insurance Company Name

Policy Holder's Employer | *Employer Phone #*

SECONDARY *Policy Holder's Full Name* | *Relationship to Patient*

Policy Holder Social Security # | *DOB (mm/dd/yyyy):* | *Policy Holder Address (if different than patient)*

Insurance Company Name

Policy Holder's Employer | *Employer Phone #*

GETTING TO KNOW YOU

1. Is another member of your immediate family (living at the same address) a patient in our practice? If yes, whom?

2. Whom may we thank for referring you?

3. Person to contact for emergency: *Phone Number:*

HIPAA PRIVACY CONTACTS

I am providing written permission for Champaign Dental to speak to, or leave messages at, any of the following numbers regarding my dental appointments and/or treatment.:

Name: _____ | *Name:*

Phone #: _____ | *Phone #:*

Relation: | *Relation:*

_____ _____ _____

Signature of Responsible Party | Relationship | Date