Patient Information

Confidential

Patient's Name: _____
First Middle Last

Address: _____
Street City State Zip

Birthdate: _____ Social Security No: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Check Appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's employer: _____ Work Phone: _____

Business Adress: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

If patient is a Student, Name of School/ College: _____ City: _____ State: _____

Person to Contact in Case of an emergency: _____ Phone: _____

If patient is minor, give parent's or guardian's name: _____ ☐ Male ☐ Female

Relationship to patient: _____

Whom may we thank to referring you to our office? _Name: _____

Phone: _____ Updates: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to patient: _____
First Middle Last

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Insurance Information

Insured's Name: _____ Insured's Soc.Sec. No: _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Co. Address: _____ Phone: _____

Is policy through an employer: _____ Employer's Name: _____

Do you have dual coverage? _____ Yes ___ No _____ If Yes: Which is primary? _____

Second insurance (dual coverage) _____

Insured's Name: _____ Insured's SS No. _____

Insurance Co. Group No. Local No. _____

Insurance Co. Address: _____ Phone: _____

Employer's Name

RESPONSIBITLY DISCLAIMER

I acknowledge that I am responsible for payment of all services rendered by Harchand Singh, DDS & Associates. I understand that, as a courtesy, their office will bill my insurance or me, but that I am ultimately responsible for my charges, regardless of what my dental insurance may or may not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ **Date:** _____