Atlantis Dental Care, P.A.

Please Print

Today's date:					
PATIENT INFORMATION					
Last name: First: M.I.					Is this your legal name?
Nickname:	SSN:	Birth date: / /	Sex: ❑ M ❑ F		
Street address:		Home phone : ( )		Cell phone: ( )	
City:	State: ZIP Code:		Email:		
Occupation:	Employer:			Work phone: ( )	
Referred to office by (please check one box):					
❑ Family/Friend	Name of Person who referred you:				
❑ Website	❑ Insurance Plan	❑ Location	❑ Dr.		
	❑ Other:				
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible/subscriber:	Birth date: / /	Address (if different):		Home phone : ( )	
Occupation:	Employer			Work phone : ( )	
Primary insurance	Group #	ID #			
Subscriber's name:		Birth date:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary insurance (if applicable):	Subscriber's name:		Group no.:	ID #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home # ( )	Work # ( )