Persona Dental Group

Welcome!

CHART#_____

Patient Information

Date_____

Name: (☐Mr/☐Mrs./ ☐Ms.) _____ _____ _____ Gender: ☐M ☐F
Last First Middle

Date of Birth: _____ Social Security#:_____ Driver License#: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Address:_____City:_____ Zip_____

Email Address_____ May we contact you by Email? ☐ Yes ☐ No
*** We promise not to spam you. ***

Person to contact in case of emergency_____ Phone_____

Responsible Party (If same as above, please skip)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____
Name: _____ Social Security#:_____ DL#: _____
Date of Birth:_____ Employer_____ Email _____
Address:_____City:_____ Zip_____
Cell Phone: _____ Work Phone: _____ Home Phone: _____

	Primary Insurance	Secondary Insurance
Insured Name		
Insured SSN		
Date of Birth		
Relationship to Insured	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		
Insurance Company		
Group#/Plan#		
Member ID		
Insurance Phone#		

Getting to know you

Occupation _____ Hobby _____

What is your main dental concern? _____
What is your preferred appointment day and time?
Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____
How did you hear about our office? (If a friend or family referred you, whom may we thank?)

_____

I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I authorize payment directly to the dentist of any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by or paid by my insurance for whatever reason. I authorize release of any information relating to any dental claim(s). By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.

_____ _____
Signature of Responsible Party or Patient (Parent if Patient is a Minor.) Date

www.personadentalgroup.com

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