SAMUELS DENTAL ARTS P.C.

Patient Information

Name: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Home Address: _____

_____

SS#: _____

Date of Birth: _____

Employer: _____ Subscriber's Employer: _____

Occupation: _____

Dental Insurance Subscriber: _____

Dental Insurance Subscriber Date of Birth: _____ and SS#: _____

Dental Insurance Company: _____ Address: _____

Group Number: _____ ID Number: _____

Spouse's Name: _____ Work Phone Number: _____

Nearest relative not living with you: _____

Relative's Phone Number: _____

Physicians Name: _____ Former Dentist: _____

Who may we contact in the event of an emergency? _____

Relationship: _____ Phone Number: _____

Who may we thank for referring you to our office? _____

Who is financially responsible for this account? _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the above answers to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Indicate your relationship to the patient: Patient _____ Guardian/Representative _____

Print Name: _____

Signature: _____ Date: _____

1650 Biglerville Road ❖ Gettysburg, PA 17325 ❖ 717-334-0555
www.gettysburgfamilydentist.com