MOUNTAIN SHADOWS FAMILY DENTAL

Please tell us about yourself

Today's Date: _____

Patient's Name: _____ **Preferred Name:** _____

Address: _____ Date of Birth: ___/____/_____

City: _____ State: _____ Zip: _____ Sex: ☐ Male / ☐ Female

Social Security: _____-____-_____ **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Mobile Number: (_____)_____ Home/Other: (_____)_____

Employer: _____ Occupation: _____ Work Number:(_____)_____

Email Address: _____

Emergency Contact Name: _____**Number:** (_____)_____

Who may we thank for referring you to us for care?

☐ Friend/Family: _____ ☐ Internet: _____

☐ Newspaper ☐ Insurance Company

☐ Other: _____

If the Patient is a minor, please tell us about you, are you the parent or guardian

Your Name: _____ Relationship to Patient: _____

Your Address: _____ Your Home Phone: _____

(If different from the patient) Your Cell Phone: _____

City: _____ State: _____ Zip: _____ Your Social Security: _____-_____-_____

Dental Insurance Information (Primary)

Insurance Company: _____ Insurance Phone: _____

Name of Insured Person: _____ Insured Date of Birth: _____

SS or ID # of the Insured: _____ Group Number: _____

Employer Name: _____ Work Phone: _____

Dental Insurance Information (Secondary)

Insurance Company: _____ Insurance Phone: _____

Name of Insured Person: _____ Insured Date of Birth: _____

SS or ID # of the Insured: _____ Group Number: _____

Employer Name: _____ Work Phone: _____