

# Sierra Crest Dental Patient Information Form

Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
First Middle Last

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell # \_\_\_\_\_ Home phone \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Email \_\_\_\_\_

Check Appropriate Box  Minor  Single  Married  Divorced  Widowed  Separated

If college student, F.T/P.T., name of school \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Patient or parent's employer \_\_\_\_\_ Work phone \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Whom may we thank for referring you \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home phone \_\_\_\_\_

Driver's license # \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Is this person currently a patient in our office  Yes  No

## Dental Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

Do you have any additional dental insurance  Yes  No If yes, complete the following:

Name of insured \_\_\_\_\_ Soc. Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or local # \_\_\_\_\_ Work phone \_\_\_\_\_

Employer address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Tel. # \_\_\_\_\_ Grp. # \_\_\_\_\_ Policy/I.D. # \_\_\_\_\_

Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible \_\_\_\_\_ How much have you used \_\_\_\_\_ Max annual benefit \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of patient (or parent, if minor)

\_\_\_\_\_  
Date