Welcome To **Keystone Dentistry**

Date ___/___/___

Thank you for taking time to complete this form for our records!

PATIENT INFORMATION

Last Name ____________________ First Name______________________ MI____
Date of Birth _____/_____/_____ SSN ____-____-_____ Gender: M ___ F ___
Address ____ Apt #___________
City ___________________________ State ______ Zip Code ___________________
Home Phone (____) ____ - ______ Work Phone (____) ____ - _______ Ext________
Cell Phone (____) ___ - _______E-Mail Address _____________________________
Employer's Name____
If Married Spouse's Name ____

WE'RE HAPPY YOU CHOSE US! HOW DID YOU SELECT US?

Doctor or Staff Referral Who? ____
Personal Referral Who? ____
Location? ___ Yes ___ No Other, please tell us more_________________________

FINANCIALLY RESPONSIBLE PARTY

Last Name ____________________ First Name ___________________MI_____
Date of Birth _____/_____/_____ SSN ____-____-_____Gender: M _____ F____
Home Address ____ Apt # ___________
City ___________________________ State _____________Zip Code ____________
Home Phone (____) _____ - _______ Work Phone (_____)____ - _______ Ext _______
Cell Phone (____) ___ - _______E-Mail Address _____________________________
Employer's Name ____

EMERGENCY CONTACT

Person outside of immediate family to contact in case of emergency

Name _______________________________________Phone (___) ____ - __________
Relationship ____________________________

INSURANCE INFORMATION

Name of Insured________________________ Insured's SSN ____ - ____ - _______
DOB ____/____/____ Group Number ___________
Insured's Employer____
Insurance Company ______________________Phone (___)____- ______________
Address __________________________City _____________ State ____ Zip ________
Patient's relationship to Insured ____

Name of Insured________________________ Insured's SSN ____ - ____ - _______
DOB ____/____/____ Group Number ___________
Insured's Employer____
Insurance Company ______________________Phone (___)____- ______________
Address __________________________City _____________ State ____ Zip ________
Patient's relationship to Insured ____