PATIENT INFORMATION

Today's Date:_____

(must be filled out completely)

Preferred Dentist: Fletcher – Holliday

Patient's full name:_____

Name Preferred:_____ Birthdate:_____ Age:_____

SS#:_____ Sex: M F Marital Status: M D W S

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

Address:_____ City:_____ St._____ Zip:_____

Patient's Employer:_____

E-Mail:_____

Whom may we thank for referring you?:_____

Emergency contact and numbers:_____

Patient relation to emergency contact:_____

Person Responsible for Payment

Name:_____ Birthdate:_____ SS#_____

Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

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

Employer of responsible person:_____

Employer's Address:_____

Dental Insurance Information

Policy holder:_____ ID#:_____ birthdate of insured:_____

Employer of insured:_____ SS#of insured:_____

Insurance Company:_____ Group#:_____

Address:_____ City:_____ State:_____ Zip:_____

Insurance Telephone#:_____

I authorize release of information to my insurance company and I authorize payment directly to Dr. Fletcher, Dr. Holliday, Dr. Otterpohl or Dr. Connor

Signature:_____ Date:_____