



Samuels Dental Arts

Patient Information

Name: _____

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

Email: _____

Home Address: _____

SS#: _____

Date of Birth: _____

Employer: _____

Subscriber's Employer: _____

Occupation: _____

Dental Ins. Subscriber: _____

Dental Ins. Subscriber: Birth date: _____ SS#: _____

Dental Ins. Company: _____ Address: _____

Group Number: _____ ID Number: _____

Spouse's Name: _____ Work Phone: _____

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.

Patient's or Guardian's Signature _____ Date: _____