Elect Chart _____

PATIENT INFORMATION SHEET

(Office Use) (Please fill out completely)

PATIENT INFORMATION: □ MALE □ FEMALE DATE:_____

Name _____ DOB: _____ SS#_____
Last First Mid Initial

Street Address_____
City State Zip

Mailing Address (if different)_____ E-Mail*:_____

Home Phone _____ Cell Phone* _____

Employer _____
Name Address Phone #

Emergency Contact _____
Name Relationship Phone #

PARENT OR GUARDIAN INFORMATION: (All patients 17/under must have this section completed)

Name _____ Relation to Patient _____
Last First Mid Initial

DOB: _____ SS# _____ E-Mail:_____

Home Phone (____)_____ Cell Phone (_____)_____

Employer _____
Name Address Phone #

Do You Have Insurance? Yes □ No □

Insurance Co. Name

_____

Subscriber Name

_____

DOB: _____

SS#_____

Subscriber's

Employer_____

Subscriber #

_____

Group #

_____

Relationship

_____

Secondary Insurance Co. Name

_____

Subscriber Name

_____

DOB:

_____SS#_____

Subscriber's

Employer_____

Troy Family Dental

1118 Ocean Beach Hwy. * Longview, WA 98632 * Phone 360-423-5240 * Fax 360-501-5391

Elect Chart _____

PATIENT INFORMATION

SHEET

(Office Use)

(Please fill out completely)

Subscriber # _____

Relationship _____

Group # _____

If you do not show for your appointment or cancel with less than 48 hours notice, a fee of $50 will be charged to your account. You will be personally responsible for this charge. I understand that responsibility for dental services provided in this office for myself or my dependents, regardless if covered by insurance, is mine.

Patient or Guardian Signature: _____ Date: _____

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