Sugar Hill Corners
Family and Cosmetic Dentistry

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Patient information Form

Name: _____ _____ _____Date of Birth: _____
First Middle Last

Address: _____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone_____ Work Phone:_____

Email: _____ Soc. Security #:_____

Check Appropriate Box: Gender: ☐ Female ☐ Male Family Status: ☐ Married ☐ Single ☐ Minor ☐ Other

Person to contact in case of an Emergency: _____ Phone:_____ Relationship_____

Whom may we thank for referring you to our practice? _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient_____

Address_____Best contact Phone #_____

Employer_____ _ Work Phone #_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance information

Name of Insured_____DOB_____Soc. Security#_____

Name of Employer_____ Work Phone #_____

Insurance Company Name_____ Ins phone #_____

Insured's relationship to patient_____

Let us see your family smile!