PENDERGRASS AND WILKIE
DENTISTRY

Patient Information

Patient Name: _____ **Date:** _____
Last First MI

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other**
_____

Social Security #: _____ **Birth Date:** _____

Phone (Home): _____ **(Work):** _____ **Ext:** _____

Phone (Cell): _____ **Email Address:** _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary
Name of Insured: _____ **Is Insured a Patient?** ☐ **Yes** ☐ **No**
Last First MI

Insured's Birth Date: _____ **Social Security #:** _____

Group #: _____ **ID#**_____

Insured's Address: _____
Street City Zip Code

Insured's Employer Name: _____

Patient's Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Insurance Plan Name and Address: _____

Employment Information

The following is for: ☐ **The Patient** ☐ **The Person Responsible for Payment**

Employer Name: _____ **Occupation:** _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ **Existing Patient** ☐ **Another Dental Office** ☐ **Yellow Pages**

☐ **Internet/Google Search** ☐ **School** ☐ **Work** ☐ **Other** _____

Name of person or office referring you to our practice_____