

# PATIENT INFORMATION



Tony L. Ramos DMD

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we are happy to help.*

**Date** \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Check Appropriate Box:  Minor  Single  Married

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank you for referring you? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

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

NOTE: Financial Policy must be reviewed and signed by responsible party / guarantor.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security N<sup>o</sup>. \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or Local N<sup>o</sup>. \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group N<sup>o</sup>. \_\_\_\_\_ ID N<sup>o</sup>. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**Do you have additional insurance?**  Yes  No *If yes, complete the following:*

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security N<sup>o</sup>. \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Union or Local N<sup>o</sup>. \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group N<sup>o</sup>. \_\_\_\_\_ ID N<sup>o</sup>. \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

NOTE: Provide copy of insurance card. If covered by multiple insurance policies, please provide a card for each policy.