

**CONFIDENTIAL PATIENT INFORMATION**

Art Carpenter, DDS, Ltd.  
Family & Cosmetic Dentistry

Date: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Prefer to be addressed by: first name last name nickname \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Telephone (Home): \_\_\_\_\_ Telephone (Business): \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Telephone(Home): \_\_\_\_\_ Telephone(Business): \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Primary Insurance Co.: \_\_\_\_\_  
NAME

STREET CITY STATE ZIP

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Please bring your insurance card to your first visit

Credit Card information

Visa  Mastercard  Discover

Name on Card: \_\_\_\_\_ Number: \_\_\_\_\_ Exp: \_\_\_\_\_

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: X

Date: