PATRICK C. PENDLETON
D.D.S. F.A.G.D.

Patient Information (Confidential)

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____
Home phone _____ Cell# _____ Soc. Security # _____ Birth date _____
Email _____ Please confirm my appointments by: E-mail Home Phone Cell Phone (circle one)
Check Appropriate Box □ Minor □ Married □ Divorced □ Widowed □ Separated □ Single

If college student, F.T./P.T., name of school _____ City _____ State _____
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 for referring you _____
Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Driver's license # _____ Birth date _____ Soc. security # _____
Employer _____ Work phone _____
Is this person currently a patient in our office □ Yes □ No

Insurance Information

Name of insured _____ Relationship to patient _____
Birth date _____ Soc. security # _____ Date employed _____
Name of employer _____ Union or local # _____ Work phone _____
Employer address _____ City _____ State _____ Zip _____
Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____
Ins. Co. address _____ City _____ State _____ Zip _____
Do you have any additional <u>dental</u> insurance □ Yes □ No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birth date _____ Soc. security # _____ Date employed _____
Name of employer _____ Union or local # _____ Work phone _____
Employer address _____ City _____ State _____ Zip _____
Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____
Ins. Co. address _____ City _____ State _____ Zip _____

× _____ _____
Signature of patient or parent of minor Patient account number