www.suewalkerdentistry.com
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# PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit

Name ______________________________ Soc. Sec. # ________-____-________ DOB ______________
Last First Middle

Home Address ______________________________ City ______________ State _____ Zip _________
Street

( _____ ) _________ - _________ ( _____ ) _________ - _________ ______________________________
Home Phone Cell Phone E-mail

Employer ______________________________ Occupation ______________________________

Employer Address ______________ ______________ _____ _________ ( _____ ) _________ - _________
Street City State Zip Work Phone

Marital Status (Check One): ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner

Spouse/Parent ______________________________ Soc. Sec. # ________-____-________ DOB ______________

Spouse Address ______________ ______________ _____ _________ ( _____ ) _________ - _________
Street City State Zip Spouse Phone

Spouse Employer ______________ ______________ ______________ _____ _________ ( ____ ) ______ - _______
Name Address City State Zip Work Phone

**If someone other than the PATIENT is responsible for payment, complete the following:**

Responsible Party ______________ ______________ ______________ _____ _________
Name Address City State Zip

Relationship to patient ______________________ Soc. Sec. # ________-____-________ ( _____ ) _________ - _________
Home Phone

Employer ______________ ______________ ______________ _____ _________ ( ____ ) ______ - _______
Name Address City State Zip Work Phone

**In case of EMERGENCY:**

Relative to contact (other than spouse) ______________________________ ( _____ ) _________ - _________
Name Phone

Other person to contact (Not relative) ______________________________ ( _____ ) _________ - _________
Name Phone

**How do you intend to pay?:** ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance ❑ Other ______________________

Primary Insurance Co. ______________________ ______________________ ( _____ ) _________ - _________
Name Address Phone

Name of Insured ______________________ ______________________ ______________________
Policy Number Group Number

Secondary Insurance Co. ______________________ ______________________ ( _____ ) _________ - _________
Name Address Phone

Name of Insured ______________________ ______________________ ______________________
Policy Number Group Number

**Has any member of your family ever been treated in our office:** ❑ Yes ❑ No Name: ______________________

**Whom may we thank for referring you to our office:** Name: ______________________________

**Are you available on short notice?:** ❑ Yes ❑ No Best Phone Number to be reached at: ______________________

***Over - Please see back side for Authorization and Terms***