Chico Dental Care

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Patient Information (Confidential)

SS #____________________
Date _______________

Name____Birthdate______________Home Phone _______________
E-mail Address____Cell Phone_________________
Address____City__________________State_______Zip_____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College___________________City_________State_______ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer_____________________________________Work Phone_______________
Employer Address________________________________City__________________State_______Zip_____________
Spouse or Parent/Guardian's Name____________________Employer_______________Work Phone_______________
Emergency Contact____Phone____________________
Primary Care Physician____Phone____________________

How did you hear about our office? ____

Responsible Party (Complete if Parent/Guardian of patient is financially responsible)

Name of Person Financially Responsible for this Account_________________Relationship to Patient___________
Address____Home Phone______________________
E-mail Address____Cell Phone______________________
Driver's License #____________________State______Birthdate_____________________________________
Employer________________________________Work Phone______________SS #_____________________
Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured____Relationship to Patient_________________
Birthdate_________________SS #_________________________________
Employer______________________Union or Local #___________Work Phone________________________
Employer Address____________________City____________________State____________Zip_______________
Insurance Company____________________Group #__________________Policy/ID #_________________________
Insurance Co. Address___________________City_____________________State____________Zip_______________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ **Yes** ☐ **No** *****IF YES, COMPLETE THE FOLLOWING**

Name of Insured____Relationship to Patient_________________
Birthdate_________________SS #_________________________________
Employer Name______________________Union or Local #___________Work Phone________________________
Employer Address____________________City____________________State____________Zip_______________
Insurance Company____________________Group #__________________Policy/ID #_________________________
Insurance Co. Address___________________City_____________________State____________Zip_______________