

Carolina Smile Center

Jeff T. Blank, DMD, PA

Welcome

Patient Information

Today's Date _____

Birthdate _____ Social Security # _____

Name _____ Nickname _____

? Male ? Female ? Minor ? Single ? Married ? Divorced ? Widowed

Address _____

City, State, Zip _____

Home Phone () _____ Cell Phone () _____

Email Address _____ Are you a Student?? Yes? No

School/University _____ Status: ? Full Time ? Part-Time

Employer _____ ? Full Time ? Part-time

Work Address _____ City, State, Zip _____

Work Phone _____ Ext _____ Work Fax _____

Occupation/Position _____

How did you hear about our office? _____

Are you covered by dental insurance?? Yes ? No

Insurance Carrier Name _____ Group Number _____

Responsible Party

Who is responsible for the financial account of this patient?

Name _____

Relationship to patient _____

Birthdate _____ Driver License _____

Social Security # _____

Home Address _____

City, State, Zip _____

Home Phone () _____ Cell Phone () _____

Employer _____ ? Full Time ? Part-time

Work Address _____ City, State, Zip _____

Work Phone _____ Ext _____ Work Fax _____

Occupation/Position _____

Emergency Contact

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____