Name: ______________________________
ID: ________________________________
DOB: ______________________________

Crider Health Center
Dental Services Patient Information

Today's Date:______________
Name of person completing this form:______________________ Relationship to Patient: __self __parent __other________
How did you hear about us:__ family/friends __ yellow pages __ newspaper __ other_____________________

Instructions
Please answer the following questions regarding yourself, or if you are representing a child, about the child.

Personal Demographic Information

Full Name:____ Birthdate:___________ Male___ Female___

Social Security#:_________________ Home Phone #:___________Work#_____________ Cell#_____________

Street Address:_____________________________________City:______________________ Zip:_____________

Marital Status: _____never married _____married _____separated _____divorced _____widowed

Race/Ethnicity:__Asian __Pacific Islander __Black/African Amer. __Amer. Indian/Alaska Native __Hispanic/Latino

__White (non-Hispanic/Latino __unknown

Preferred Language:_______________________ Any hearing, vision, learning or other disabilities we should be aware of?

If yes, please explain.____

Do you require an additional assistance to help us serve you better? ___language interpreter ___wheelchair ___assistive equipment ____
(Please explain)

Spouse /Parent/ Guardian (if applicable-required if patient is a minor):

Full Name:____ Birthdate:___________ Soc. Security#_______________

Relationship to Patient:_______________ Home Phone #:______________Work#___________ Cell#_____________

Please check if the address is the same □

Street Address:____________________________________City:__________________________ Zip:______________

Insurance Information:

Insurance Provider:_____________________________ Policy #___________________ Group#__________________

Policy Holder's Name:__________________________________ Birthdate:___________ Social Security#_____________

Secondary Insurance Provider:_________________________ Policy#____________________ Group#_____________

Policy Holder's Name:__________________________________ Birthdate:___________ Social Security #_____________

Emergency Contact Information:

Name of person not living with you: _____________________________________ Relationship:____________________

Address:____ City__________________________ Zip_____________

Phone#__________________________ Work#_______________________ Other#____________________________

I herby give lifetime authorization for payment of Insurance benefits to be made directly to Crider Health Center for any services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Crider Health Center to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:____ Date:________________

Routing: Front of the form to be copied and routed to AP (Judy Lynch);
back side will go into the patient file