PATIENT INFORMATION

Clemson Family Dentistry

Today's Date: _____
Patient Name:_____
Preferred Name: _____

Date of Birth: ___ / ___ / _____
Social Security Number: _____

Street Address: _____ City: _____ State: ____ Zip: _____
Mailing Address (if different than above): _____
Home Phone: _____ Cell Phone: _____ Business Phone: _____
Email Address: _____

Occupation: _____ Employer/School: _____

Are other family members patients in our office? _____
If yes, Please list: _____

How did you hear about our office? Who recommended our office? _____

Previous Dentist: _____ City: _____

DENTAL INSURANCE

If you have dental insurance that you would like us to file on, please fill out the following information:

Insurance Company: _____
Subscriber: _____
Subscriber's DOB: _____

I have answered all questions truthfully. I, or the above named person, guarantee payment of all fees incurred by this patient, I give permission for dentists, dental assistants, and dental hygienists to perform treatment for which they are qualified and allowed by law.

Signature of Patient/Legal Guardian: **Date:**

_____ _____