

# Schramm Dentistry

## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Relationship to Responsible Party:  Self  Spouse  Child  Parent or Legal Guardian

Employer Name \_\_\_\_\_ No. of Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_ Student  Full time  Part time

Parents (if patient is a minor) Father's Name \_\_\_\_\_ Work # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work # \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### *EMERGENCY CONTACT INFORMATION:*

Name of Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## Responsible Party Information

Name (if different from above) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Employer Name \_\_\_\_\_ No. of Years Employed \_\_\_\_\_

Occupation \_\_\_\_\_ Student:  Full time  Part time

## Insurance Information

Insured Name \_\_\_\_\_ Insured Social Security No. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Do you have dual coverage?  Yes  No If yes,

Insured Name \_\_\_\_\_ Insured Social Security No. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

**Signature** \_\_\_\_\_