Patient Information

Patient Name: ____ Date:___________
Last First M

Address: ____
Street Apt # City State Zip

Birth Date: ____/_____/______ Telephone: Home: _______________ Work:_______________ Cell:_______________

Sex: ☐ M ☐ F Check Appropriate: ☐ Minor ☐ Single ☐ Married ☐ Widowed

If Student: ____ Full Time ☐ Part Time ☐
Name of School / College City State Grade

Occupation: _______________________ SS#:_________________

E-mail Address: ____

Emergency Contact: __________________________________ Relationship: _____________ Phone: ______________

Whom may we thank for referring you: ____

If same as above please check box and skip to next section: ☐

Person responsible for this account: ___________________________________ Relationship to Patient:______________

Address (if different from above):______________________________ City: _______________ State: ______ Zip:________

Birth Date: ____/_____/______ Telephone: Home: _______________ Work:_______________ Cell: _______________

SS#: _____________________

Primary Dental Coverage Information

If you don't have a dental insurance, please check: ☐

Name of Insured:__________________________________ Relationship to patient: ___________ Birth date: ___________

Address (if different from above): _________________________________ City: _________________ State: ____ Zip: ______

SS #: ________________________ Name of employer: _________________________________ Union/Local #: ________

Address of employer: _______________________________________ City: _________________ State: ____ Zip:_______

Dental Insurance Company: _________________________ Group #: ______________ Policy/ID #: ________________

If you have Secondary Dental Insurance Coverage, please give your dental card to the front desk.

Medical Insurance Information:

Name of Insured:__________________________________ Relationship to patient: ___________ Birth date: ___________

Address (if different from above): _________________________________ City: _________________ State: ____ Zip: ______

SS #: ________________________ Name of employer: _________________________________ Union/Local #: ________

Address of employer: _______________________________________ City: _________________ State: ____ Zip:_______

Medical Insurance Company: _________________________ Group #: ______________ Policy/ID #: ________________

Your privacy is confidentially retained and used only for your dental care; I authorize Joy Dental Associates to release my information, if necessary, for my dental treatment. I authorized to receive e-mails and text from the office as well.

I agree to be responsible for all charges for dental services and materials not paid by dental insurance or the agreed treatment plan amount.

Patient Signature: ____ Date: ____________________________

If minor: Parent/ Guardian's Name: ____

Signature: ______________________________ Date: _____________________________