



DENTAL SURGEONS & IMPLANT CENTERS OF FALL RIVER, DARTMOUTH, AND MIDDLEBORO

PATIENT INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____
*If the above address is a Po Box, you **must** provide a street address.

Home Phone No. _____ Cell Phone No. _____

SS# _____ Date of Birth _____ Age _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If a student Name of School _____ City _____ State _____

Employer _____ Work Phone No. _____

Work Address _____ City _____ State _____ Zip _____

Person to contact in case of an Emergency _____ Phone No. _____

Responsible Party – Parent or Guardian if Minor

Name _____ Relationship To Patient _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ SS# _____ Home/Cell Phone# _____

Responsible Party Signature _____ Date _____

For your convenience, we offer the following methods of payment. Please check the option you prefer, payment in full at each appointment:

- Cash Personal Check Credit Card 3rd Party Payment Plan

INSURANCE INFORMATION

First _____ Middle _____ Last _____ Relation to Patient if other then Patient _____

Date of Birth _____ Social Security Number _____

Employer _____ Work Phone Number _____

Employer Address _____ City _____ State _____ Zip _____

Medical Ins. Co. _____ Group # _____ Subscriber # _____

Dental Ins. Co. _____ Group # _____ Subscriber # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No **If yes please complete the following:**

First _____ Middle _____ Last _____ Relation to Patient if other then Patient _____

Date of Birth _____ Social Security Number _____

Employer _____ Work Phone Number _____

Employer Address _____ City _____ State _____ Zip _____

Medical Ins. Co. or Dental Co. _____ Group # _____ Subscriber # _____

Please provide card(s) and photo ID. A photocopy is needed to verify benefits and eligibility.