LIBRARY PLAZA DENTAL CENTER
FAMILY, COSMETIC, & IMPLANT DENTISTRY

Name _____

Date ____/____/____

PATIENT INFORMATION **Birthdate** ____/____/____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Phone: (Please circle preferred)

Home _____ Mobile _____ Work _____

May we contact you by email? ☐ Yes ☐ No Email Address _____

Emergency Contact _____ Phone _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name _____

Responsible Party (if patient is a minor) _____

Relationship to Patient _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

How did you hear about our office? _____

Previous dentist's name _____ Phone _____

Office address _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____/_____/_____ Subscriber ID # _____ Group # _____

Insurance Company _____ Insurance Company Phone # _____

Employer _____

Do you have additional insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Subscriber Birthdate _____/_____/_____ Subscriber ID # _____ Group # _____

Insurance Company _____ Insurance Company Phone # _____

Employer _____