reardon DENTISTRY

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Home Phone _____

Check appropriate box: ◯ Minor ◯ Single ◯ Married

If Student, name of school/college _____

City _____ State _____ ◯ Full Time ◯ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Employer Address _____

City _____ State _____ Zip _____

Spouse's or Parent's Name _____

Spouse's or Parent's Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Person responsible for this account _____

Relationship to patient _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Social Security # _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? ◯ Yes ◯ No

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

◯ CareCredit® Finance Plan

◯ I wish to discuss the office's payment policy.