JSA DENTAL CARE ASSOCIATES
PATIENT INFORMATION

Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Patients Name____
(Last) (First) (Middle)
Address____
Home Phone__________________________ Cell Phone______________________________________
Employer___________________________________ E-mail____________________________________
Work Phone_________________________________

Patients Date of Birth_____________ Sex________ Social Security Number________________________

Marital Status (Circle) Single Married Widowed Separated Divorce Minor Other

***IF PATIENT IS A MINOR, LEGAL GUARIDANS NAME _________________________________**
***IF PATIENT IS A MINOR, NAME OF SCHOOL/COLLEGE________________________________**

Spouse or Parent Information

Name_________________________________ Employer____
Date of Birth____________________ Social Security Number___________________________________
Cell Phone #________________________________ Business Phone #_____________________________

Person Responsible for account ____________________________Relationship to patient__________

PRIMARY INSURANCE INFORMATION

Dental Insurance Company ______________________________Phone Number______________________
Insured Name________________________________ Date of Birth__________________________________
Social Security Number____________________________ ID # on Insurance Card___________________
Group/Policy Number__________________________

SECONDARY INSURANCE INFORMATION

Dental Insurance Company ______________________________Phone Number______________________
Insured Name________________________________ Date of Birth__________________________________
Social Security Number____________________________ ID # on Insurance Card___________________
Group/Policy Number__________________________

General Information

Please tell us whom we may thank for referring you to us______________________________________

Has any member of your family been treated in our office? Yes No

Name of nearest relative or friend ____________________________Phone #______________________

Name of Previous Dentist______________________________ Date of last cleaning_________________

Name of Physician_________________________________ Phone#______________________