ANCHOR DENTAL

Welcome to our Practice

PATIENT INFORMATION

DATE: _____

FIRST: _____ MI: _____ LAST: _____

STREET: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DRIVER'S LICENSE #: _____ PATIENT SSN: _____ PATIENT DOB: _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

EMAIL: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

IF STUDENT
NAME OF SCHOOL/COLLEGE: _____ CITY: _____ STATE: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT THE OFFICE? _____

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

STREET: _____ APT #: _____ CITY: _____ STATE: _____ ZIP: _____

SSN: _____ DOB: _____ HOME PHONE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

WORK PHONE: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

INSURANCE INFORMATION

PRIMARY DENTAL
POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____ DOB: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ INSURANCE: _____

GROUP NUMBER: _____ MEMBER ID: _____ INSURANCE ADDRESS: _____

SECONDARY DENTAL
POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____ DOB: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ INSURANCE: _____

GROUP NUMBER: _____ MEMBER ID: _____ INSURANCE ADDRESS: _____

Southside Corporate Center, 5595 Transportation Blvd., Suite 250, Garfield Heights, OH 44125
p (216) 475-0505 **f** (216) 475-9290 www.anchordental.net