Carolina
Family Dentistry

Welcome

We are pleased to have you as a guest in our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, please feel free to ask. We look forward to being of service to you.

Patient Information:

Name: _____ Soc. Sec # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Email address: _____ Date of Birth: _____

Sex: M F Marital Status: Single Married Widowed Separated Divorced

Patient employed by: _____ Occupation: _____

How do you plan to pay for today's visit? _____ Cash/Check _____ MC/Visa/Debit

Dental Insurance:

Person responsible for account: _____
Last name First name Middle Initial

Relationship to patient:_____ Date of Birth:_____ Soc. Sec. #:_____

Responsible party's employer: _____ Business phone:_____

Insurance company: _____ Phone number: _____

Group number: _____ Patient ID: _____

Name of other dependants under this plan: _____

Please complete below if patient is a minor (under 18 years):

Mother's Name: _____ Soc. Sec. #:_____ Date of Birth:_____ Work phone: _____

Father's Name: _____ Soc. Sec. #:_____ Date of Birth:_____ Work phone: _____