PATIENT INFORMATION

Welcome to Clear Sky Dental Care

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☒ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Preferred Contact Method for Confirmations: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Preferred Contact Method for Recall: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☒

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____