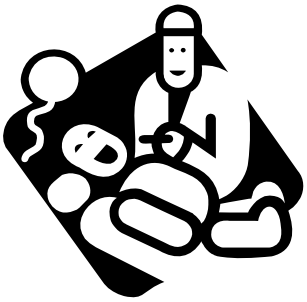
Park Village Dental Group



Welcome

Patient Information (CONFIDENTIAL)

Name:_____Birthday:_____ SS#/SIN: _____
Address: _____
City:_____ Zip Code: _____E-Mail: _____
Home Phone:_____ Work Phone: _____Cell Phone: _____
Person to Contact in Case Of Emergency:_____ Phone: _____
When was the last visit to the dentist?: _____
Whom May We Thank for Referring You?:_____
Please circle: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College: _____ City: _____
State: _____ Are you Over 18?:_____ if NO, Responsible info needed below

Responsible Party (if the patient is under 18 years old)

Name Of Responsible Party: _____ Relationship to Patient: _____
Address: _____ City: _____ ZipCode:_____
Home Phone:_____ Work Phone: _____Cell Phone: _____
Birthday: _____ SS#/SIN: _____ Driver License #: _____
Is This Person Currently a Patient in Our Office? ___ Financial Institution: _____

Full Payment Required for Service Rendered.

Insurance Information (only for the patients with insurance)

Name of the Insured: _____ Relationship to Patient:_____
Birthday: _____ SS#/SIN: _____ Date Employed: _____
Name Of Employer: _____ Union or Local#: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: _____
Insurance Company: _____ Group #: _____ Policy ID:_____
Ins Co. Address: _____ City: _____ State: _____
How Much is your Deductible?: _____ Max. Annual Benefit: _____
When was your last visit to the dentist?: _____
Do you have any additional Insurance? Please let us know.

Please fill out the back

Please present your Insurance Card and your Driver's License to the Front Office when Finished.