

# Wayne & Julie Scott, D.D.S., P.A.

## Patient Information

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First MI

Driver's License #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Male  Female Marital Status \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell) \_\_\_\_\_

In case of an emergency call \_\_\_\_\_ Phone \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice? \_\_\_\_\_

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment (parent/guardian of minor MUST be present)

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

## Dental Insurance Information

**Primary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID# or SS#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Co. Name and Phone#: \_\_\_\_\_