KURT CARLSON DMD

THE PEAK OF DENTISTRY

Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## Patient Information

Name _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____ Personal Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

## Responsible Party

Name of person responsible for this account? _____

Relation to Patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone # _____

## Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. Name _____ Plan or Group # _____ ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone # _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ NO ☐ YES IF YES, PLEASE COMPLETE THE FOLLOWING

Name of Insured _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Date Employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. Name _____ Plan or Group # _____ ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone # _____