Oak Ridge Family Dental

Please complete this form in ink. If you have any questions, please do not hesitate to ask our staff. We are here to help!

Patient Information:

Full Name _____ Date _____

Address _____ City _____ State/Zip _____

Birthdate _____ Male ____ Female ____ Home Phone _____

Cell Phone _____ Work Phone _____

Where do you prefer to take calls? Home _____ Work _____ Cell _____

Marital Status: Single ____ Married _____ Divorced _____ Widowed _____ Minor _____

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____

Business Address _____ City _____ State/Zip _____

How did you hear about our office? _____

Who can we thank for referring you? _____

Emergency Contact _____ Phone # _____

Responsible Party (if patient is a minor):

Name of person financially responsible for this account _____

Relationship to patient _____ Phone # _____

Employer Address _____City _____State/Zip_____

Insurance Subscriber (Check here ____ if subscriber is the patient and skip section)

Name of Insured _____Relationship to Patient _____

Subscriber Birthdate _____ Subscriber Social Security # _____

Employer _____ Occupation _____

Business Address _____City _____State/Zip _____