PAUL J. STEELE, D.D.S., P.C.

PATIENT INFORMATION

Name____ SSN_______-_______-_______
Last First M.I.

Gender M ☐ F ☐ Age______ Birthdate______/______/______ ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
MM DD YYYY

Street Address ______________________________ City____________________ State_______ Zip___________

Mailing Address (*if different*)______________________________ City____________________ State_______ Zip___________

Home phone____________________ Cell phone*____________________ Email____________________

I consent to dental practice of Dr. Paul Steele using my cell phone number to call regarding appointments, treatment, insurance, and my account. I may withdraw consent at any time. ______
(Initial)

Employer______________________________ How long? __________ Work phone ____________________

Spouse's name ____________________ Spouse's Employer______________________________ How long? ________

Emergency Contact______________________________ Phone______________________________

Whom may we thank for referring you? ____________________ Is this appointment a result of an auto or other accident? _______

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN SELF)

Name____ SSN_______-_______-_______
Last First M.I.

Address______________________________ City____________________ State_______ Zip___________

Gender M☐ F☐ Age______ Birthdate______/______/______ Relationship to patient____________________
MM DD YYYY

Home phone ____________________ Cell phone ____________________ Email ____________________

Employer______________________________ Work phone ______________________________

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other

Insurance Plan Name ____________________ ID# ____________________ Group#____________________

Insurance Plan Address ______________________________ Phone Number ____________________

COMPLETE IF DIFFERENT FROM PATIENT INFORMATION:

Insured's Name ______________________________ Insured's Birthdate______/______/______ SSN _______-_______-_______
Last First M.I. MM DD YYYY

Insured's Address ______________________________ City ____________________ State _____ Zip __________

Insured's Employer ____________________ Address ____________________ City ____________________ State ____ Zip ________

SECONDARY DENTAL INSURANCE

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other

Insurance Plan Name ____________________ ID# ____________________ Group#____________________

Insurance Plan Address ______________________________ Phone Number ____________________

COMPLETE IF DIFFERENT FROM PATIENT INFORMATION:

Insured's Name ______________________________ Insured's Birthdate______/______/______ SSN _______-_______-_______
Last First M.I. MM DD YYYY

Insured's Address ______________________________ City ____________________ State _____ Zip __________

Insured's Employer ____________________ Address ____________________ City ____________________ State ____ Zip ________

Signature of Patient or Responsible Party______________________________ **Date**____________________