WELCOME TO CHAPEL HILL DENTAL ARTS

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Date_____

Patient Information

Cell Phone _____
Home Phone_____
Work Phone_____
Name_____ SS #_____
Last First Initial
Address _____
City_____State_____ ZIP_____
Sex ☐M ☐F Age____ Birth Date __/__/____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed By_____Occupation_____
Business Address_____ Driver's License #_____
Referral _____Emergency Contact_____ Phone_____

Primary Insurance

Person Responsible for Account_____
Last First Initial
Relation to Patient_____ Birth Date__/__/____ SS # _____
Address (*if different from patient's*) _____
City_____State_____ ZIP_____
Person Responsible Employed By_____Occupation_____
Business Address_____ Business Phone_____

Insurance Company_____ Group #_____Subscriber SS #_____
Name of Other Dependents Covered Under This Plan_____

Additional Insurance

Is Patient Covered By Additional Insurance ☐ Yes ☐ No
Person Responsible for Account_____
Last First Initial
Relation to Patient_____ Birth Date __/__/__ SS # _____
Address (*if different from patient's*) _____
City_____State_____ ZIP_____
Person Responsible Employed By_____Occupation_____
Business Address_____ Business Phone_____

Insurance Company_____ Group #_____Subscriber SS #_____
Name of Other Dependents Covered Under This Plan_____