



# COOL SPRINGS DENTISTRY

Kathryn Spencer, D.D.S.



## Patient Information (Confidential)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Check Appropriate Box  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College/University: \_\_\_\_\_

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy of Choice \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party (If other than self)

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

Is This Person Currently a Patient in our Office?  YES  NO

For your convenience we offer the following methods of payment. Please Check the option you prefer.

Payment in full at each appointment.  Cash  Personal Check  VISA  Master Card  Discover

I wish to discuss the offices' payment policy

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Do You Have Additional Insurance? YES NO If Yes, Complete Following:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_