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The Dental Group
at Carpenter's Crossing
 34359 Carpenter's Way
 Lewes, DE 19958

Chart #: _____
 FOR OFFICE USE ONLY

About You

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____

What You Prefer To Be Called: _____ e Male e Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

_____ CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____ CITY STATE ZIP

Occupation: _____

Status: e Minor e Single e Married e Divorced e Separated e Widowed

Spouse's Name: _____

Do you have children? e Yes e No How Many? _____

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____ CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Account Information

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____ CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment Method: e Cash e Check

_____ / _____

e Credit Card - Enter card # above (if accepted)

Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

In Event of Emergency

Whom should we contact? _____

Relation: _____

Home #: (____) _____

Work #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

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