JEREMY ARCHIBALD DDS

FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Welcome! To assist us in serving you, please complete the following forms. The information provided is strictly confidential, and will be used to provide personalized and individual care. If you have any questions, please do not hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____

Home address: _____

City:_____ State: _____ Zip: _____

Billing address (if different): _____

City: _____ State: _____ Zip: _____

Email address: _____

Home telephone: _____ Cell Phone: _____ Bus. Phone:_____

Preferred Method of Contact:

☐Home Phone ☐Cell Phone ☐Business Phone ☐Email

Emergency Contact Name (relationship): _____Emergency Contact #_____

SS#: _____ Drivers License #:_____

Employer/Occupation: _____

Primary Dental Insurance

Primary dental insurance: _____ Group #: _____ Phone #: _____

Insurance Company Address: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Subscriber's employer: _____

Secondary Dental Insurance

Secondary dental insurance: _____ Group #: _____ Phone #: _____

Insurance Company Address: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Subscriber's employer: _____

I certify that I have read and answered all questions on intake forms truthfully and to the best of my knowledge. I authorize Dr. Archibald & employees to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependents to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to Dr. Archibald. I authorize Dr. Archibald to perform an initial examination and obtain necessary radiographs (x-rays) to evaluate my oral condition and provide a diagnosis to me.

Signature of Patient (or parent/guardian if minor):_____ Date:_____