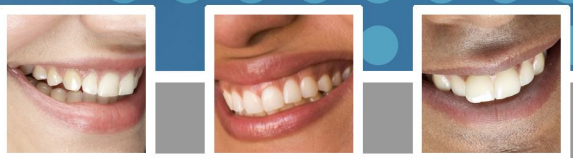
Dental Care, P.C.
415 E. Coolbaugh
Red Oak IA 51566

(712)623-3383



Patient and Insurance Information

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ Prev. Visit: _____ Email Address: _____

Phone:* _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address:* _____ _____

* _____ * _____ * _____
City State Zip Code

The following is for:* ☐ the patient ☐ the person responsible for payment

Employer Name:* _____ Phone: _____

Address: _____ _____

_____ _____ _____
City State Zip Code

Who may we thank for referring you?

_____

Person to contact and their phone number in case of emergency:

* _____

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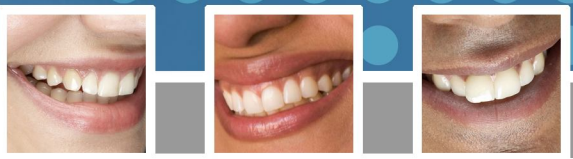

Responsible Party

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: * _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: * _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address: * _____ _____
* _____ * _____ * _____
City State Zip Code

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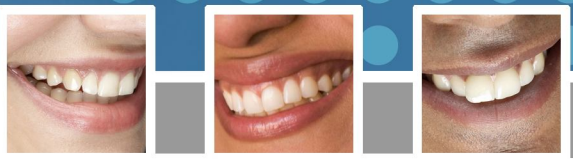

DENTAL Insurance Information

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____
City State Zip Code

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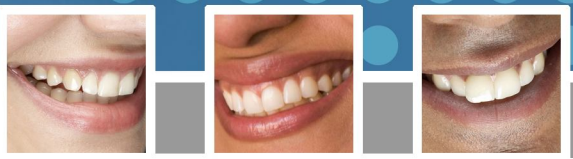

Additional (Secondary) DENTAL Insurance Information

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____
City State Zip Code

Response Date: _____