flint hills
DENTAL, PA

Personal Information

Name of Patient _____ Date_____

Male_____ Female_____ Date of Birth_____ Social Security Number_____

Home Phone_____ Cell Phone_____ Email_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____ Ext._____

Occupation_____

Preferred Method of Contact:

Home_____ Cell_____ Work_____ Email_____

Responsible Party

Name_____ Relationship to Patient_____

Home/Cell/Work Phone_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Dental Insurance Information

Name of Insured_____ Relationship to Patient_____

Insured's DOB_____ Social Security Number _____ Employer_____

Insurance Company_____ Phone Number_____

Member ID/Number_____ Group Number_____

Other Information

Referred by_____

Emergency Contact_____ Relationship_____

Phone_____

Reason for todays visit_____