Sierra Crest Dental
Patient Information Form

Name _____ Preferred Name: _____
First Middle Last

Mailing Address _____ City _____ State ____ Zip _____

Cell # _____ Home phone _____ Email _____

Preferred method of contact: Home Cell Text Email

Soc. Security # _____ Birthdate _____

Employer _____ Work phone _____

Single Married Divorced Widowed Other Name _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Preferred Pharmacy _____ City _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Is this person currently a patient in our office 0 Yes 0 No

Dental Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate: _____ Soc. Security # _____ I.D.# _____

Name of employer _____ Work phone _____ Group # _____

Insurance Co. _____ Tel. # _____

Insurance Address: _____ City: _____ State _____ Zip _____

I _____ acknowledge receipt of Notice of Privacy Practices.

X_____ _____
Signature of patient (or parent, if minor) **Date**