1654 Bryan Rd • O'Fallon, MO 63368
Phone (636) 978-4848 Fax (636) 978-4862
www.dardennedental.com

3820 Elm St • St. Charles, MO 63301
Phone: (636) 916-4848 • Fax (636) 916-1004
www.elmdentalcare.com

128 Professional Pky • Troy, MO 63379
Phone: (636) 528-4868 Fax: (636) 528-4869
www.familydentalintroy.com

PATIENT INFORMATION

Name ______ LAST ______ FIRST ______ MI ______ MR. MRS. MS. DR. TITLE - CIRCLE ONE

Address ______ NUMBER & STREET ______ CITY ______ STATE ______ ZIP

___ - ___ - ___ SOC. SECURITY NUMBER ( ) AREA CODE ______ HOME PHONE ( ) AREA CODE ______ BUSINESS / ALTERNATE PHONE

M F SEX ______ DATE OF BIRTH ______ YOUR OCCUPATION ______ YOUR EMPLOYER ______ YRS WITH FIRM

( ) - ______ FAX ______ EMAIL ADDRESS

RESPONSIBLE PARTY INFORMATION

______ RESPONSIBLE PARTY OCCUPATION ______ EMPLOYER ______ YRS WITH FIRM

Name ______ LAST ______ FIRST ______ MI

Address ______ NUMBER & STREET ______ CITY ______ STATE ______ ZIP ( ) ______ AREA CODE AND PHONE NUMBER

( ) AREA CODE ______ BUSINESS PHONE ___ - ___ - ___ SOC. SECURITY NUMBER M F SEX ______ DATE OF BIRTH

DENTAL INSURANCE INFORMATION

Employer ______ COMPANY NAME ______ ADDRESS - # AND STREET ______ CITY

______ STATE ______ ZIP ( ) AREA CODE ______ EMPLOYER'S PHONE ______ GROUP NUMBER ______ INSURANCE I.D.#

______ INSURANCE COMPANY NAME ______ ADDRESS # & STREET ______ CITY

______ STATE ______ ZIP ______ AREA CODE ______ INSURANCE PHONE NUMBER ______ EXTENSION

ADDITIONAL INFORMATION

______ SPOUSE'S OCCUPATION ______ EMPLOYER ______ YRS WITH FIRM

Spouse ______ FIRST NAME AND MI ______ DATE OF BIRTH ______ SOC. SECURITY NUMBER ( ) ______ BUSINESS PHONE & EXT

IF COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON? ______

Emergency contact ______ NAME ______ DAYTIME PHONE ______ EVENING PHONE

I LEARNED OF YOUR OFFICE BY: _ Referred By ______ _Phone Book _ Office Sign _ Other ______

I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. IF I DEFAULT IN PAYMENT AND COLLECTION IS REQUIRED, I WILL BE RESPONSIBLE FOR ALL COLLECTION AND/OR ATTORNEY FEES AND COURT COSTS.

______ DATE ______ SIGNATURE OF PATIENT OR GUARDIAN