Today's Date _____ / _____ / _____   **E-mail** _____

Name: _____ / _____
        Last,   First,   MI   I prefer to be called

Address: _____
        Street   City   State   Zip

Date of Birth _____ / _____ / _____   Gender: ☐ M ☐ F   Social Security # _____

Telephone (home) _____ (cell) _____ (work) _____ Ext: _____

Can we call you at work? ☐ Yes ☐ No   Best time to call: _____

Emergency Contact _____ Phone _____ Relationship to Patient _____

Responsible Party (person responsible for payment)

Name: _____
        Last,   First,   MI

Address: _____
        Street   City   State   Zip

Date of Birth _____ / _____ / _____   Social Security # _____   Drivers License #/State _____

Telephone (home) _____ (cell) _____ (work) _____ Ext: _____

Relationship to patient _____   Is insured a patient? ☐ Yes ☐ No   Gender: ☐ M ☐ F

Insurance Information:
Primary *Dental* Insurance

Name of Insured	Insured's Birth Date	Insured's Social Security Number
Patient's Relationship to Insured	ID#	Group#
Insured's Employer Name	Employer's Address	City, State, Zip
Insurance Plan Name	**Insurance Plan Address**	**Insurance Plan Phone** ( )

Secondary *Dental* Insurance

Name of Insured	Insured's Birth Date	Insured's Social Security Number
Patient's Relationship to Insured	ID#	Group#
Insured's Employer Name	Employer's Address	City, State, Zip
Insurance Plan Name	**Insurance Plan Address**	**Insurance Plan Phone** ( )

Primary *Medical* Insurance

Name of Insured	Insured's Birth Date	Insured's Social Security Number
Patient's Relationship to Insured	ID#	Group#
Insured's Employer Name	Employer's Address	City, State, Zip
Insurance Plan Name	**Insurance Plan Address**	**Insurance Plan Phone** ( )

Secondary *Medical* Insurance

Name of Insured	Insured's Birth Date	Insured's Social Security Number
Patient's Relationship to Insured	ID#	Group#
Insured's Employer Name	Employer's Address	City, State, Zip
Insurance Plan Name	**Insurance Plan Address**	**Insurance Plan Phone** ( )

Carolinas Center for Oral Health

Patient Acquaintance Form

4904 (12/09)

Patient Information or Label

Name:

DOB:

Medical Record #: