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 #:

Job: CP6820
J0106885
4904
1st proof: 12/30/09
Ink: Black
Paper: 20# Green