CENTER FOR DENTAL EXCELLENCE
• STEPHEN DELOACH, DDS, DPC •

PATIENT INFORMATION

Name_____ Date_____
SS#/SIN_____ Birthday_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Email_____ Cell Phone_____
Check Appropriate Box:
☐ Minor ☐ Single ☐ Married ☐ Separted ☐ Divorced ☐ Widowed

Name of School/College_____ City_____ State_____ Zip_____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Spouse Name_____ Employer_____ Work Phone_____

Whom may we thank for referring you?_____
Person to contact in case of an emergency_____Phone_____

RESPONSIBLE PARTY

Name of responsible party_____ Relationship_____
Address_____ City_____ State_____ Zip_____
Email_____Home Phone_____
Driver's License #_____ Birthday_____Cell Phone_____
Employer Address_____Work Phone_____SS/SIN#_____

Is this person currently a patient at this office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the payment policy

INSURANCE INFORMATION

Name of Insured_____ Relationship_____
Birthday _____ SS/SIN#_____ Date Employed_____
Name of Employer _____Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/I.D.#_____
Ins. Company Address_____ City_____ State_____ Zip_____
How much is your deductible?_____ How much have you used?_____ Max Annual Benefits_____

Do you have any additional insurance coverage? ☐ Yes ☐ No (If yes complete the following)

Name of Insured_____ Relationship_____
Birthday _____ SS/SIN#_____ Date Employed_____
Name of Employer _____Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Policy/I.D.#_____
Ins. Company Address_____ City_____ State_____ Zip_____
How much is your deductible?_____ How much have you used?_____ Max Annual Benefits_____