Paul D. Ellzey, DDS | DATE: _____ | EllzeyDental.com

PATIENT INFORMATION (Please Print)

_____

Patient Last Name | Patient First Name | Patient Middle Initial | Jr. / Sr. / Other

CELL #: (____) _____ HOME #: (____) _____ EMAIL ADDRESS: _____

Address: _____ City / State: _____ Zip Code: _____

Sex: _____ M _____ F Age: _____ Date of Birth: _____

____ Married ____ Separated ____ Widowed ____ Divorced _____ Single ____ Minor with Parent / Guardian

Patient Employer / School: _____ Occupation: _____

Employer / School Address: _____ Employer / School Phone (____) _____

Emergency Contact: _____ Relationship to Patient: _____ Cell #: (____) _____

New Patients: How did you hear about EllzeyDental? _____

Covered by Dental Insurance? ____ Yes ____ No (If No, Proceed to Responsible Party Section)

DENTAL INSURANCE

Primary Insurance (Please provide insurance card)	Secondary Insurance (Please provide insurance card)
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Patient's Relationship to Subscriber: ___Self ___Spouse ___ Child ___ Other	Patient's Relationship to Subscriber: ___Self ___Spouse ___ Child ___ Other
Subscriber Employer Name: _____	Subscriber Employer Name: _____
Employer Name: _____	Employer Name: _____
Employer Phone #: (____) _____	Employer Phone #: (____) _____
Insurance Company: _____	Insurance Company: _____
Insurance Phone #: (____) _____	Insurance Phone #: (____) _____

RESPONSIBLE PARTY – (Please Provide Copy of Driver's License, if not Patient)

Person Financially Responsible: _____

Last Name | First Name | Middle Initial | Jr. / Sr. / Other

Relationship to Patient: ____Self (no additional info needed) ____Spouse ____ Guardian

Address: _____

Cell #: (____) _____ Work #: (____) _____ Employer: _____

Email Address: _____