

# OSKY DENTAL

-WE LOVE TO SEE YOUR SMILE-

Who may we thank for referring you? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Do you currently have a dentist? \_\_\_\_\_

Email: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

How would you like us to contact you? HOME CELL Work Email

SSN: \_\_\_\_\_ CIRCLE ONE: Minor Single Married Divorced Separated

If Patient is minor are parents: Married Divorced Separated Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Ext: \_\_\_\_\_

## RESPONSIBLE PARTY

-if other than patient-

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## DENTAL BENEFITS

Policy Holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

## SECONDARY DENTAL BENEFITS

Policy Holder: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE OF PATIENT OR PARENT (if minor)