

# LOGAN RIDGE

## —DENTAL—

### BLAKE CAMERON, DDS

#### **PATIENT INFORMATION**

(Required)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
E-Mail \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Child \_\_\_\_\_  
Social Security# \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Preferred Method of Contact (*please circle*)    **Text**    **Phone**    **E-mail**

(If Applicable)

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

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

#### **RESPONSIBLE PARTY**

(Required if patient is a minor)

Person Responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Social Security # \_\_\_\_\_ (Required)  
Address if different from above \_\_\_\_\_  
Birthdate \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

#### **INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy/ ID# \_\_\_\_\_  
Insurance address \_\_\_\_\_ Group plan# \_\_\_\_\_  
Phone # \_\_\_\_\_ How much is the Deductible? \_\_\_\_\_

Do you have additional insurance? If yes, complete the following:

Name of Insured \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy/ ID# \_\_\_\_\_  
Insurance address \_\_\_\_\_ Group plan# \_\_\_\_\_  
Phone # \_\_\_\_\_ How much is the Deductible? \_\_\_\_\_

• CARING FOR YOUR SMILE •