

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? _____