Patient Information

Patient Name: _____ Date: _____
Last, First MI

I prefer to be called _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Widowed ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐Radio 92.9 ☐Radio 95.7

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Spouse Information

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Employer: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Group #: _____
Last First MI

Insured's Birth Date: _____ SS#:_____ ID #: _____

Name of Insurance: _____ Insurance Co Phone # _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

I authorize the use of my study models and/or photographs for lectures or publications by Dr J Brad Bynum.

_____ Date: _____
Signature of patient, parent or guardian