RALPH M. GREEN, D.M.D.
LEWIS C. JONES, D.M.D., M.D.
GREGORY A. WAY, D.M.D., M.D.
MATTHEW STRATTON, D.M.D., M.D.

PATIENT'S FULL NAME: _____ **DATE OF BIRTH:**_____

PATIENT'S ADDRESS: _____ **CITY**_____**ST**_____**ZIP**_____

PATIENT'S HOME PHONE:_____ **/CELL PHONE:**_____ **/WORK PHONE:** _____

PATIENT'S SOCIAL SECURITY NUMBER: _____ **PATIENT'S AGE:**_____

PATIENT'S MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED

PERSON RESPONSIBLE FOR THIS ACCOUNT (IF OTHER THAN PATIENT)_____

PERSON RESPONSIBLE SOCIAL SECURITY NUMBER:_____

PATIENT/PARENT EMPLOYER: _____

SPOUSE'S NAME: _____ **EMPLOYER:** _____ **WORK PHONE:**_____

DO YOU HAVE DENTAL INSURANCE? YES OR NO DO YOU HAVE MEDICAL INSURANCE? YES OR NO

IF YES, COMPLETE THE INSURANCE INFORMATION LISTED BELOW:

CARDHOLDER'S NAME (IF OTHER THAN PATIENT) _____

SOCIAL SECURITY NO._____ **DATE OF BIRTH:**_____

CARDHOLDER'S EMPLOYER_____ **ADDRESS:** _____

CITY:_____ **ST:**_____ **ZIP:** _____

INSURANCE COMPANY NAME: _____ **GROUP#:**_____

ADDRESS: _____ **CITY:**_____ **ST:**_____ **ZIP:** _____

PHARMACY NAME & PHONE#:_____

REFERRED BY:_____

NAME OF DENTIST:_____

NAME OF PHYSICIAN:_____

EMERGENCY CONTACT: _____

HOME PHONE (OTHER THAN PATIENT'S): _____ **WORK #:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS OKAY TO SPEAK WITH _____ **REGARDING MY TREATMENT AND ACCOUNT**

I _____**, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.**

SIGNATURE_____ **DATE**_____ **OK TO TEXT** _____

OPT OUT _____