Dr. James J. Richart

Family-Restorative-Cosmetic
Dentistry

Patient Information

Today's Date_____
Patient Name_____
Last First MI
What you prefer to be called:_____
Birthdate:_____Age:_____Male/Female
SS#_____
Mailing Address:_____
_____
City State Zip
Home Phone:_____
Work Phone:_____
Other Phone:_____
E-mail Address:_____
Occupation:_____
Employer:_____How Long?____
Employer's Address:_____
_____
Status(circle one): Married Single Divorced Seperated Widowed
Spouses Name: _____
Do you have any children? Yes/ No How Many?____
Who may we thank for Referring you?_____
_____

Account Information

Person ultimately responsible for account
Name:_____
Relation:_____
Billing Address:_____
_____
City State Zip
SS#_____
Drivers License #_____
Work Phone#: _____

_____:I herby authorize assignment of my
Initials rights and benefits driectly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company.

Insurance Information:
Primary Dental Insurance

Company Name:_____
Address:_____
Phone #_____
Insured's SS#_____
Group #_____
Insured's Name: _____
Relation:_____Date of Birth_____

Secondary Dental Insurance:

Company Name:_____
Address:_____
_____
Phone #:_____
Insured's Name_____
Insured's SS#:_____
Relation:_____Date of Birth_____

EMERGENCY INFORMATION

In the event of Emergency who should we contact:_____
_____
Relation:_____
Home Phone:_____
Work Phone:_____
Who is your Medical Doctor?_____
Dr.'s Phone #:_____

PHARMACY INFORMATION

What Pharmacy do you use:_____
_____
Phone # of Pharmacy:_____

Please Read Back of this sheet and sign if you have dental Insurance !