CONFIDENTIAL PERSONAL INFORMATION

Patient Legal Name _____ Nickname _____

Date of birth _____-_____-_____ Sex: M F Soc Sec # _____-_____-_____

Address _____

City, State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation_____

Primary Physician_____ Phone _____

***Have you ever been a patient of Dr. Massey in the past? Yes No**
***Referring Dentist _____Regular dentist_____**
***Did you bring an xray with you? Please give to front desk with your paperwork**
***Would you like to have Nitrous Oxide sedation (available for an additional charge?) Yes No**

Emergency Contact
Name: _____Phone:_____

Responsible Party (if other than patient):
Name _____ Relationship to Patient _____

Address_____ Phone _____

Date of birth _____-_____-_____ Soc Sec # _____-_____-_____

Primary Dental Insurance:
Company_____

Employer_____

Group # _____ Subscriber ID # _____

Name of Insured _____ Birthdate _____-_____-_____

Soc Sec # _____-_____-_____

Secondary Dental Insurance:
Company_____

Employer_____

Group # _____ Subscriber ID # _____

Name of Insured _____ Birthdate _____-_____-_____

Soc Sec # _____-_____-_____

Is the problem you are seeking treatment for the result of an accident? Yes No
If so, is medical, auto, or other third party insurance available? Yes No

Other Insurance _____

Note: We will file Dental Insurance as a courtesy to our patients for services provided. You are responsible for the estimated portion at time of service and any fees not covered by your Dental Insurance Company.