Welcome to Richland NorthEast Dental!

We are committed to help you with all of your dental needs.
*Please fill out this form **completely**.*
Should you have any questions or need assistance, please ask us.

Date_____ **DL #** _____
SSN_____

Patient Information (Confidential)

Name_____**Preferred Name**_____ **M/F**

Birth date _____ **Home Phone**_____ **Work Phone** _____**Cell Phone** _____

Address_____**Apt#**_____**City/State/Zip**_____

Married _____**Single**_____ **Child**_____ **Other** _____ **is Patient a Student? Yes** ____**No**_____

E-Mail_____

Patient's or Parent's Employer_____

Employer's Address_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ **Phone:** _____

Responsible Party (If different from patient) Relationship

Name of Person Responsible for this Account _____ **to Patient** _____

Address_____ **Apt#** _____ **City/State/Zip** _____

Birth date _____ **Social Security Number**_____ **Home Phone** _____

Employer _____ **Work Phone** _____ **Cell Phone**_____

Is this person currently a patient in our office? Yes _____ **No**_____

Insurance Information Relationship

Name of Insured_____ **to Patient** _____

Birth date_____ **Social Security Number #**_____ **Home Phone**_____

Employer _____**Work Phone**_____

Insurance Company_____ **Group Number**_____

Insurance Co. Address_____**City/State/Zip**_____

ADDITIONAL DENTAL/MEDICAL INSURANCE Relationship

Name of Insured_____ **to Patient**_____

Birth date_____ **Social Security Number #**_____ **Work Phone**_____

Employer_____ **Insurance Company**_____

Group Number_____

Insurance Co. Address_____**City/State/Zip**_____