

Patient Information

Columbia City Dental

Name _____ Preferred Name _____

Email _____ Is it OK to email you? No Yes

Home phone ____ - ____ - ____ Work phone ____ - ____ - ____ Cell phone ____ - ____ - ____

Would you like to receive text reminders for appointments? No Yes

Preferred way to contact _____

Street address _____

City _____ State ____ Zip _____

Date of birth ____ / ____ / ____ SSN ____ - ____ - ____

Referred by _____

Emergency contact name _____

Emergency contact phone ____ - ____ - ____

Is patient a student? No Yes

If yes, name of school _____

Patient employment status Not employed Full-time Part-time

Marital status Single Married Divorced Widowed Other

Other family members seen at this office _____

Do you have dental insurance? No Yes

If yes, please bring insurance card(s) for dental coverage to your visit.

Your relationship to subscriber Self Spouse Child

Subscriber Name _____ Subscriber ID # _____

Subscriber DOB ____ / ____ / ____ SSN ____ - ____ - ____

Insurance Company _____ Phone ____ - ____ - ____

Employer _____

Group Name _____ Group # _____

Preferred gift choice:

Amazon Starbucks Ark Lodge Cinemas Andaluz Empire Espresso Columbia City Bakery