Today's Date: _______________

The Dental Center

815 38th Street SE, Cedar Rapids, IA 52403

(319) 365-0534 phone / (319) 297-7417 fax / info@crdentalcenter.com email

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

Patient's Legal Name: ______________________ Prefer to be Called: ______________ Male: ____ Female: ____

Birthdate: __________ Age: ____ SS #: __________ DL #: __________ Email: ____________________

Street Address: ______________________ City: ______________ State: ____ ZIP: ________

Hm #: (____) __________ Cell #: (____) __________ Appointments Should be Confirmed at: Cell: ____ Hm: ____ Wk: ____

Single: ____ Married: ____ Divorced: ____ Widowed: ____ Separated: ____ Person Responsible for Account: ______________

Employer or School: ______________ Job Title (if applicable): ______________ Wk #: (____) __________ Ext ________

Employer or School Street Address: ______________________ City: ______________ State: ____ ZIP: ________

New Patients: Which of our doctors do you prefer to see for your dental care? (choose one)

Chris Haganman, DDS, MS: ______ Brad Stovie, DDS: ______ Shannon Hingst, DDS: ______ No Preference: ______

Previous/Current Dentist: ______________ Last Visit Date: __________ How did you hear about us? ______________

Other Family Members Seen by Us: ______________ ______________ ______________ ______________

PERSON RESPONSIBLE FOR ACCOUNT (if under 18, Mother and Father information must be supplied)

Legal Name: ______________ Birthdate: ______________ SS #: ______________ DL #: ______________

Relationship to Patient: ______________ Hm #: (____) __________ Cell#: (____) __________ Wk#: (____) __________

Street Address: ______________________ City: ______________ State: ____ ZIP: ________

Employer: ______________________ Job Title: ______________________

Employer Street Address: ______________________ City: ______________ State: ____ ZIP: ________

Legal Name: ______________ Birthdate: ______________ SS #: ______________ DL #: ______________

Relationship to Patient: ______________ Hm #: (____) __________ Cell#: (____) __________ Wk#: (____) __________

Street Address: ______________________ City: ______________ State: ____ ZIP: ________

Employer: ______________________ Job Title: ______________________

Employer Street Address: ______________________ City: ______________ State: ____ ZIP: ________

DENTAL INSURANCE (Primary)

Insured's Name: ______________ Relation: __________ Insured's Birthdate: __________ SS#: ______________

Insured's Employer: ______________ Insurance Co: ______________ ID: ______________ Group #: __________

Ins Co. Address: ______________ City: ______________ State: ____ ZIP: ________ Phone: (____) ________

DENTAL INSURANCE (Secondary)

Insured's Name: ______________ Relation: __________ Insured's Birthdate: __________ SS#: ______________

Insured's Employer: ______________ Insurance Co: ______________ ID: ______________ Group #: __________

Ins Co. Address: ______________ City: ______________ State: ____ ZIP: ________ Phone: (____) ________

CONTACT IN CASE OF EMERGENCY

Name: ______________ Relation: __________ Cell #: (____) ________ Hm #: (____) ________ Wk #: (____) ________

The following are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name: ______________ Relation: ______________ Name: ______________ Relation: ______________

I understand that the information I have given today is correct and to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time the service is rendered.

This office reserved the right to verify the credit status of patients and/or parents of minor patients.

Patient Signature (or Guardian/Parent if under 18): ______________________ Date: ______________