# Angel Dental Care

**PATIENT INFORMATION:** Please fill out ALL information clearly and accurately.

Date: ________________________ Email ____________________________________________________________________

Name: ________________________________________________ Age _________ Sex __________ Home Phone ( ) _________________
Last First MI

Address: ________________________________________________ Apt __________________________ Cell Phone ( ) _________________

City: ___________________________________ State: _________ Zip __________________________ Work Phone ( ) _________________

Birthdate: ________________ SSN ________-_____-_______ Driver's License Number___________________________________ State _____

Marital Status: ☐ Single ☐Married ☐Divorced ☐Separated

Employer: ___________________________________________ Employer's Address ______________________________________________________

In case of emergency, contact: ________________________________________ Relation: ______________________ Phone ( ) _________________

Are any of your family members patients of this practice? ☐YES ☐NO Name(s) and relation: _________________________________________________

**PAYMENT INFORMATION:** Payment is due at time of service. As a courtesy to our patients with insurance, we will submit the claim. We require the patient to supply us with their credit card information for any balances that might be due once we receive notification from your insurance company.

How would you like to pay for your visit/copay? ☐Cash ☐Visa ☐M/C ☐American Express ☐Discover ☐Care Credit

Account #_________________________________________Expiration Date______________________ Verification Code______________________________

Would you like to apply for ☐Care Credit or ☐Capital One Healthcare Financing? (Minimum $300.00)
Address Credit Card is billed to: ____________________________________________________________________________________________

**REFERRAL INFORMATION:** Who may we thank for referring you to Angel Dental Care?

☐My children come here ______________________ ☐ Friend ______________________ ☐ Relative ______________________

☐ Co-worker _____________________ ☐ My Dentist______________________ ☐ My Physician ______________________

☐ Existing patient _________________ ☐ Insurance Provider Directory ☐ Insurance Internet web site ☐ Google ☐ Yahoo ☐ MSN

☐ Yellowpages.com ☐ Superpages.com ☐ Community Phone Book (Red) ☐ Patuxent Directories Phone Book (Black) ☐ Verizon Phone Book (Yellow)

☐ Building sign ☐ Your Health Magazine ☐ Woman's Health Magazine

**SPOUSE or RESPONSIBLE PARTY INFORMATION:**

Name: ________________________________________________Age _________ Sex __________ Home Phone ( ) ____________________
Last First MI

Address: ________________________________________________Apt __________________________ Work Phone ( ) ____________________

City: ______________________________ State: _________ Zip __________________________ Mobile Phone ( ) ____________________

Birth date: ___________SSN _____-_____-_____ Email _____________________________ Driver's License Number ___________________State _____

Employer: ____________________________________________ Employer's Address ______________________________________________________

**INSURANCE INFORMATION:**
Primary Insurance Plan Name & Address: _______________________________________________________ Phone Number: ______________________

Name of Insured: _______________________________________________ D.O.B. ________________ SSN: _______-_______-______
Last First MI

Group #: _____________________________ Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured's Address: _________________________________________________________________________ Phone Number: ______________________
Street City State Zip Code

Insured's Employer: ________________________________________________ Address: ___________________________________________________