Vista Ridge Dental

8409 West Cleburne Rd • Fort Worth, TX 76123 • (817)292-5927

www.vistaridgedental.com

info@vistaridgedental.com

Patient Information

Patient Name: _____
Last First MI Preferred Name

Title: _____ **Gender:** O Male O Female **Family Status:** O Married O Single O Child O Other
Mr / Ms / Mrs / etc

Birth Date: _____ **SS#:** _____ **Previous Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Referral Information

Name of person, office or other source referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: O the patient's spouse O the person responsible for payment O both O neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ **Gender:** O Male O Female **Family Status:** O Married O Single O Child O Other
Mr / Ms / Mrs / etc

Birth Date: _____ **SS#:** _____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Employment Information

The following is for: O the patient O the person responsible for payment O both O neither-not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance

Name of Insured: _____

Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group#:** _____

Insured's Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Patient's relationship to insured: O Self O Spouse O Child O Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Secondary Dental Insurance

Name of Insured: _____

Last First MI

Insured's Birth Date: _____ **ID#:** _____ **Group#:** _____

Insured's Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Patient's relationship to insured: O Self O Spouse O Child O Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____

City State Zip Code

Please list the name and phone number of someone to notify in case of an emergency:

_____

Name Phone

Please list the name and phone number of your physician:

_____

Name Phone