BARTOSH
FAMILY DENTISTRY

Bill Bartosh D.D.S.

Patient Information (CONFIDENTIAL)

SS#/SIN _ _ _ _ - _ _ - _ _ _ _ Date___________________

Name_____________________________________Birthdate_________________Home Phone________________________

Address___________________________________City______________________State________Zip___________________

Email____Cell Phone__________________________

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, name of School/College________________________City________________State_______ Full Time Part Time

Patient or Parent/Guardian's Name__________________________________Work Phone____________________________

Business Address_____________________________________City___________________State_________Zip___________

Spouse or Parent/Guardian's Employer_____________________________________Work Phone______________________

Whom May We Thank for Referring You?____

Person to Contact in Case of Emergency____Phone____________________

Responsible Party

Name of Person Responsible for this Account__________________________________Relationship to patient______________________

Address____Home phone_________________

Email____Cell Phone____________________

Driver's License #____________________________________Birthdate____

Employer_____________________________________Work Phone_____________________SS#/SIN_________________

Is this Person Currently a Patient in Our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Cash *Personal Check* *Credit Card* *VISA* *Master Card* *I wish to discuss the office's payment policy*

Insurance Information

Name of Insured____Relationship to patient______________________________

Birthdate_______________________SS#/SIN____________________________Date Employed______________________

Name of Employer____Work Phone_______________________________

Address of Employer__________________________________City______________________State______ZIP____________

Insurance Company______________________________Group #_________________Policy/ID#_______________________

Ins. Co. Address_________________________________City___________________________State______ZIP__________