NORTHLAKE DENTISTRY
STACY SCHMITT,DDS,PA

Please fill out this form as completely as you can. Failure to provide correct information can delay and alter your treatment. If you have any questions, we would be glad to assist you!

Patient's Name _____ **Date** ____/____/____

PATIENT INFORMATION

Preferred Name: _____

Address: _____
City, State, Zip:_____
E-mail: _____
Home Phone: (____)_____
Work Phone: (____)_____ext_____
Cell Phone: (____)_____

Sex: ☐ Male ☐ Female
Birth Date: _____/_____/_____
Age: ____ years old
Marital Status: _____
Social Security #:_____-____-_____
Driver's License#: _____

Do you preferred to receive: ☐ calls at home ☐ calls at work ☐ calls on cell ☐ e-mails
Emergency Contact: _____ Phone: (____)_____
Name of Employer: _____ Phone: (____)_____
Hobbies and Interests: _____
Other family members seen by us: _____
How did you hear about us? ☐ internet ☐ phonebook ☐ fliers ☐ saw sign/ drove by office
☐ insurance company ☐ referred by: _____

RESPONSIBLE PARTY / GUARDIAN ☐ **Patient Is Responsible Party (SKIP)**

Name:_____
Address: _____
City, State, Zip:_____
E-mail: _____
Home Phone: (____)_____
Work Phone: (____)_____
Cell Phone: (____)_____

☐ Responsible Party is the Parent or Guardian of the Patient
☐ Responsible Party is the Primary Insurance Policy Holder
Birth Date: _____/_____/_____
Social Security #: _____-_____-_____
Driver's License#: _____

DENTAL INSURANCE INFORMATION ☐ **Patient does NOT have insurance (SKIP)**

Name of Insured: _____
Birth Date: _____/_____/_____
Social Security #: _____-_____-_____
Name of Employer: _____
Address:_____
City, State, Zip: _____
Phone: (____)_____

Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other
Insurance Co:_____
Group/Policy # _____
Address:_____
City,State,Zip:_____
Phone: (____)_____