



Riversbend
DENTAL

Patient Information (Confidential) **Date** _____

Name _____ I prefer to be called _____ Birth date _____
(First) (MI) (Last)

☐ M ☐ F ☐ Single ☐ Married Social Security # _____ Driver's License # _____

Address _____
(Street) (City) (State) (Zip)

Phone Numbers (List All) _____
(Home) (Work) (Cell) (Other)

Employer _____ Occupation _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Person to contact in case of emergency? _____ Phone _____

Spouse Information
 Spouse _____ Birth date _____ Soc Sec # _____
 Employer _____ Occupation _____

Responsible Party
Name on Account (Whose name is to appear on billing statements?) ☐ My Name ☐ My Spouse's Name

Confirming Appointments

We prefer to confirm appointments by email. Please list your email address here _____

If you do not have email or do not check it regularly, please list the best phone number to reach you during the day _____

Insurance			
If you will be using dental insurance, please show your dental insurance card/s to the receptionist for verification of benefits.			
Name of Primary	Subscriber #	Self	Spouse
Secondary	Subscriber#	Self	Spouse