Acquaintance Form

In this form are three sections that are very important. Please take the time necessary to accurately fill them out.

Date _____

Who can we thank for referring you to our office? _____

Patient's Name _____ Male _____ Female _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthdate _____

Cell Phone _____ Email Address _____

Driver's License # _____ SS # _____

Employer _____ Address _____ Occupation _____

Spouse's Name _____ Birthdate _____ Marital Status _____
Last First Middle

Spouse's Employer _____ Address _____

Work Phone _____ Cell Phone _____

Responsible Party Information

Name _____ Relation to Patient _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ SS # _____ Driver's License # _____

Dental Insurance Information

Insured's Name _____ Insured's SS # _____ Birthdate _____
Last First Middle

Dental Insurance Company Name & Address _____
Street City State Zip

Insured's Employer _____ Address _____ Group # _____

Do you have dual Coverage? ☐ No ☐ Yes If Yes, complete the following

Insured's Name _____ Insured's SS # _____ Birthdate _____
Last First Middle

Dental Insurance Company Name & Address _____
Street City State Zip

Insured's Employer _____ Address _____ Group # _____

Emergency Notification Information

In case of emergency, who should be notified?

Name _____ Address _____ Phone _____

Relationship _____

Personal Physician _____ Address _____ Phone _____

To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

_____
Signature of Patient or Guardian Date

I authorize the use of the radiographs, photographs, or video tape of my case for presentations or publications of Dr. Scheele.

_____
Signature of Patient or Guardian Date

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