Aesthetic Dental Arts
O'Neill S. Solanky DDS, LLC
Family Dentistry ● Aesthetic Dentistry

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/ SIN _____ BIRTHDATE_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

IF COLLEGE STUDENT, F.T./ P.T., NAME OF SCHOOL _____ CITY_____ STATE_____

PATIENT'S OR PARENT'S/ GUARDIAN'S EMPLOYER _____ CITY_____ STATE _____

BUISNESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S/ GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FORTHIS ACCOUNT _____ RELATIONSHIP TO PT. _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/ SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE: ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/ SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL# _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO _____ TEL # _____ GRP# _____ POLICY/ ID # _____

INS. CO. ADDRESS _____ CITY _____ STATE_____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/ SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL# _____ WORK PHONE _____

INSURANCE CO _____ TEL # _____ GRP# _____ POLICY/ ID # _____

_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR