SUMMIT DENTAL
J. CHAD RINEHART, DDS

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec. _____ Drivers Lic.: _____

Pref. Pharmacy: _____ Emergency Contact: _____

Emergency Contact #: _____

How did you hear about our office?

Radio: _____ Online_____ Patient_____ Other_____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder

Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____ Insurance ID: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Electronic Agreement

- I agree that the dental practice may communicate with me electronically by text and at the email address below.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing the dental practice any updates to my email address.
- I can withdraw my consent to electronic communication by calling: 828.277.6868.

Email Address (PLEASE PRINT CLEARLY)

_____

Patient Signature:_____Date:_____