



KELLI SLATE, DDS

Today's Date: _____

Personal Information

Patient: Mr. Mrs. Ms. Dr. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____
Last First MI

Male Female Married Single Divorced Widowed Separated Other

Birth date: ___/___/___ Age: _____ SS#: _____ DL# _____ ST: _____

Home #: _____ Work #: _____ Ext. _____

Cell #: _____ Pager #: _____ Best time to call: _____

Employer: _____ Occupation: _____

E-mail Address: _____

Referral Information

How did you find out about our practice: _____

Emergency Information

Name of person to contact in case of emergency: _____ Relationship: _____

Phone: _____

Phone: _____

Spouse or Responsible Party Information

Name: _____ Date: _____

Last First MI Preferred Name

Gender (M/F): _____ Marital Status: _____ Birth Date: ___/___/___ Social Security #: _____

Driver's License#: _____ E-Mail Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext. _____

Cell #: _____ Pager #: _____ Best time to call: _____

Employer: _____ Occupation: _____

Dental Insurance Information

Primary:

Name of Insured: _____ Insured's Birth Date: _____

ID#: _____ Group #: _____ Patient's relationship to insured: Self Spouse Child Other

Insurance Name: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Please complete reverse side.