Divine Dental Works
TRISCHA CLARKE, DDS & LINDSEY HELMERICH, DDS

PATIENT INFORMATION

NAME:_____PREFERRED NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP_____

PHONE (_____)_____WORK PHONE (_____)_____CELL PHONE(_____)_____

DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____

CIRCLE APPROPRIATE STATUS: MINOR SINGLE MARRIED WIDOWED SEPARATED DIVORCED

IF STUDENT, NAME OF SCHOOL:_____ FULL TIME/PART TIME

SPOUSE OR PARENTS NAME:_____EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT_____PHONE(_____)_____

EMAIL ADDRESS_____WOULD YOU LIKE TO RECEIVE EMAIL CONFIRMATION? YES / NO

RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT (CIRCLE ONE): SELF SPOUSE PARENT OTHER

NAME:_____SOCIAL SECURITY NUMBER:_____

ADDRESSS:_____CITY:_____STATE:_____ZIP:_____

PHONE(_____)_____EMPLOYER:_____WORK PHONE(___)_____

INSURANCE INFORMATION

NAME OF INSURED:_____DOB:_____RELATIONSHIP TO PATIENT:_____

SOCIAL SECURITY NUMBER:_____NAME OF EMPLOYER:_____WORK#:(___)_____

ADDRESS OF EMPLOYER:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY:_____GROUP#_____ID#_____

INSURANCE COMPANY ADDRESS:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY PHONE NUMBER:_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO

NAME OF INSURED:_____DOB:_____RELATIONSHIP TO PATIENT:_____

SOCIAL SECURITY NUMBER:_____NAME OF EMPLOYER:_____WORK#:(___)_____

ADDRESS OF EMPLOYER:_____CITY:_____STATE:_____ZIP:_____

INSURANCE COMPANY:_____GROUP#_____ID#_____