Ryan Roberson, D.D.S.
H. Bart Smith, D.D.S.
Cory Roach, D.D.S.

Patient Name:______________________________ Today's Date: ____________
Last First MI

Mailing Address:____________________ City:________________ ST:____ Zip:__________

Home Phone:______________ Mobile:______________ Work: ______________ Ext:________

Email:________________________________ SocialSecurity: ______________________

Birthday:________________ Male:___ Female:___ Married: ___ Single:___ Child:___ Other:____

Emergency Number and Contact: ____

How have you heard about us? Yellow Pages ☐ Angies List ☐ Print Ad ☐ Website ☐ Movie Theater ☐
Online Search Engine: Personal Referral: Other:

Spouse or Responsible Party Information

The following is for : ☐ The patient's spouse ☐ The person responsible for payment

Name: ____

Male: ___ Female:___ Married:___ Single:___ Child:___ Other:___

Social Security No:____________________ Birth Date:____________________

Home Phone:______________ Moblie:______________ Work______________ Ext:______

Address:______________________ City:________________ ST:___ Zip:__________

Employer Information

The following is for: ☐ The patient ☐ The person responsible for payment

Employer Name: ________________________ Occupation:____________________

Address:______________________ City:________________ ST:___ Zip:__________

Dental Insurance Information

Primary

Name of Insured:______________________________ Is Insured a patient?: Y__ N___
Last First MI

Insured Birth Date:____________ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address:____________________ City:______________ ST:___ Zip:____________

Insured's Employer Name:____

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:____

Address:____

Phone:______________ Group No.____________________ Member ID:______________

Secondary

Name of Insured:______________________________ Is Insured a patient?: Y__ N___
Last First MI

Insured Birth Date:____________ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address:____________________ City:______________ ST:___ Zip:____________

Insured's Employer Name:____

Insurance Plan Name:____

Address:____

Phone:______________ Group No.____________________ Member ID:______________