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## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First Mi

### Person Responsible for Account:

Name: \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_

Male  Female Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt/Condo #

City State Zip

Single  Married  Divorced  Widowed  Separated

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Would you like to receive reminder texts in the future?  Yes  No

E-mail: \_\_\_\_\_

### Employer:

Employer's Name \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

Length of employment: \_\_\_\_\_

Occupation: \_\_\_\_\_

When are the best times to reach you? \_\_\_\_ am \_\_\_\_ pm

Whom may we thank for referring you? \_\_\_\_\_

### Second Person Responsible for Account/Spouse:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: (\_\_\_\_) \_\_\_\_\_

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

### Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone: (\_\_\_\_) \_\_\_\_\_

Group Number (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City State Zip

### In the event of any emergency, whom should we contact?

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number