Dental Associates of Lancaster, Inc.
Dr. Jon Decker, Dr. Ryan Johnson, Dr. Matt Wilkinson
Patient Information

Patient Name: _____ Date of birth: _____ Sex: _____ Age: _____

Address: _____

home phone: _____ cell: _____ work: _____

(circle preferred contact number)

SS#:_____ (if child, parent's ss#) e-mail _____

Employer: _____ (if child, list parent's employer)

Circle one: Minor Single Married Divorced Widowed referred by: _____

Spouse/Partner name & phone #:_____

Emergency contact: _____ Relationship: _____ Phone #:_____

Primary Dental Insurance

Insured's Name/DOB/SS#:_____

Relationship: _____ Insured's Employer: _____

Ins. Co name/Ins Co. Address/Group#:_____

_____

Secondary Dental Insurance (if applicable)

Insured's Name/DOB/SS#:_____

Relationship: _____ Insured's Employer: _____

Ins. Co. name/Ins. Co. address/Group#:_____

_____

HIPPA
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office any changes in medical status.

By signing this form you are giving consent for treatment, accepting that you are financially responsible for any balance on this account regardless of insurance coverage, and acknowledge that you have received a copy of the HIPPA privacy policy.

Patient/Parent Signature: _____ Date: _____