Skyline Dental

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(541)389-4807

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Employer and Work Phone Number:

_____

_____

Occupation:

_____

_____

How do you prefer our office to contact you for appointment confirmations (more than one box may be selected)?

☐ Email ☐ Text ☐ Phone ☐ Other

Emergency Contact

Name, relationship, phone number and address of Relative or Person NOT LIVING with you

_____

_____

_____

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Subscribers Date of Birth _____

Secondary Insurance Information

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Subscribers Date of Birth _____

Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:**

_____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Responsible Party Employer and Work Number:

_____

_____

Responsible Party Occupation:

_____

_____

How would you prefer to pay for your portion of the provided services?

☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ Other

Response Date: _____