BENNINGTON DENTAL CENTER

Family and Cosmetic Dentistry

Thank you for selecting our dental health team.
We look forward to working with you in maintaining your dental health.

Patient Information: **Date:**_____

Patient Name:_____
Birth Date:_____Male:__Female:__Single:__Married:__Other:__Minor: Y N
SS#:_____Drivers License #:_____
Address:_____City:_____State:_____Zip:_____
Home Phone#:_____Cell#:_____Work#:_____
Email Address:_____Best way to reach you:_____
Employer:_____
Emergency Contact:_____Phone #:_____
Other family members seen by us?_____
How did you hear of us?_____
If referred by someone, whom may we thank for the referral?_____

Parent/Guardian information (if patient is a minor):

Name:_____Relationship to patient:_____
Birth Date:_____SS#:_____Drivers License#:_____
Address:_____City:_____State:_____Zip:_____
Home Phone#:_____Cell#:_____Work#:_____
Email Address:_____

Dental Insurance Information (Primary):

Policyholder's Name:_____Birth Date:_____SS#:_____
Insurance Company:_____Group#:_____
Employer:_____Policyholders ID#:_____
Patient Relationship to Policyholder: Self:____Child:_____Other:_____

Dental Insurance Information (Secondary):

Policyholder's Name:_____Birth Date:_____SS#:_____
Insurance Company:_____Group#:_____
Employeer:_____Policyholders ID#:_____
Patient Relationship to Policyholder: Self:_____Child:_____Other:_____