Eric Batterton DDS

PATIENT INFORMATION

Patient Name:_____Date:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

____ First Name Only ___ Proper Sr. Name _____Other:_____

Gender (M/F)_____ Marital Status:_____Driver's License No:_____

Birth Date: _____SS#_____

Address:_____

EMAIL ADDRESS_____

Phone #'s Home_____Work_____Ext._____

FAX_____ Other_____

REFERRAL INFORMATION

Name of person, office or other source referring you to our practice**.**

_____

EMPLOYMENT INFORMATION

Employer Name:_____
Address:_____
Phone No:_____

INSURANCE INFORMATION

Name of the Insured:_____
Insured's date of birth:_____
Insured's ID NO:_____GROUP #_____
Insured address if different from the one above:
Patients relationship to the insured __Self __Spouse __Child __Other
Insured's Plan Name:_____
Plan Address:_____
Phone No:_____