

## Nelson & Page Dental, P.C.

209 S. 7<sup>th</sup> Street  
Worland, WY 82401

00000194240000019424New \_\_\_\_\_ Update \_\_\_\_\_

<b>PATIENT INFORMATION:</b>		
Patient's Legal Name _____	_____	Preferred Name _____
Address _____	Zip Code _____	Home Phone _____
		(Can we leave a message? Y / N)
Sex _____	Age _____	D.O.B. _____
	SS# _____	Cell Phone _____
		(Can we leave a message? Y / N)
Email address _____		
Marital Status (check one): <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Employment Status (check one): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired		
Employer's Name _____		Work Phone _____
Employer's Address _____		(Can we leave a message? Y / N)
Spouse Name _____		Home Phone _____
Spouse Address (if different) _____		Cell Phone _____
Patient's Emergency Contact: _____		Home Phone _____
Emergency Contact Relation to Patient: _____		Cell Phone _____

<b>PARENT INFO IF PATIENT IS UNDER 18 YEARS OF AGE:</b>	
Father's Name: _____	Father's Social Security Number: _____
Father's Phone Number: _____	Father's Employer: _____
Mother's Name: _____	Mother's Social Security Number: _____
Mother's Phone Number: _____	Mother's Employer: _____

<b>DO YOU HAVE INSURANCE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Carrier _____ ID# _____	
Name of Insured _____	Insured Social Security _____
Relation to patient _____	Insured Date of Birth _____
Home Address _____	Group # _____
Employer _____	Phone _____
Employer's Address _____	
<b>SECONDARY INSURANCE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Carrier _____ ID# _____	
Name of Insured _____	Insured Social Security _____
Relation to patient _____	Insured Date of Birth _____
Home Address _____	Group # _____
Employer _____	Phone _____
Employer's Address _____	

**Nelson & Page Dental, P.C.** is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

**PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE**  
**WE REQUEST THAT ALL CANCELLATIONS WILL BE MADE AT LEAST 24 HOURS IN ADVANCE OF APPOINTMENT.**  
**CONSISTENT AND CONSECUTIVE MISSED APPOINTMENTS WILL BE SUBJECT TO DISMISSAL FROM NELSON & PAGE DENTAL, P.C.**

**NEAREST RELATIVE NOT LIVING WITH YOU**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_