CHAMBERLAIN
DENTAL HEALTH

WELCOME TO OUR PRACTICE!

Patient Information and Financial Responsibility Form. Please fill out completely Today's date ___/___/___

Patient Information

Patient Name:_______________________________________Date of birth__/__/__ M☐ F☐
last first middle

Home address: _______________________________ How long ___________ Own☐ Rent☐
Street Address

______________________________________ Phone (home):(___)_________
City State Zip Phone (work): (___)_________
Phone (cell): (___)_________

child ☐ single ☐ married ☐ divorced ☐ widowed ☐

Social Security #:____________________________Driver's License #:______________________
Occupation:_____________________________ How long at current job?______years ____months
Employer:____ Employer Phone#:_____________
Employer address:____
Street address City State Zip

Name and phone number of nearest relative not living with you:

____

Financially Responsible Party

Relationship to Patient: ☐ Self ☐ Patient's Spouse
☐ Patient's Parent ☐ Other:_____________________________

Name:____Date of birth__/__/__ M☐ F☐
last first middle

Home address_________________________________How long?___________ Own☐ Rent☐
Street address

____Phone (home) _____________
City State Zip Phone (work)_____________

Social Security #__________________________Driver License #____________________________

Occupation:_____________________________ How long at current job?______years ____months

Employer:____ Employer Phone#:_____________

Employer address:____
Street address City State Zip

How did you find out about our practice? ____