Old South Dental

Jessica Torre, D.D.S., P.C.

*Date*_____

Whom may we thank for this referral? _____

*Patient's Name*_____
Last *First* *Middle*

Address _____
Street *City/State/Zip Code*

*Home Phone*_____ *Cell Phone*_____

*Email Address*_____

*Employer*_____ *Work Phone*_____

*Birth date*_____ *Male*_____ *Female*_____

Married _____ *Single*_____ *Divorced*_____ *Widowed*_____

*Social Security No.*_____ *Occupation*_____

*If Minor, List Parents' Names: Father*_____ *Mother*_____

If you would like us to file "Insurance Claims" on your behalf, please provide us with the following information. Payment is the patient's responsibility on the day of service. Thank you.

Dental Insurance Information (Please provide a copy of your Dental Insurance Card)

*Do you have Dental Insurance? Yes*_____ *No*_____ *Name of Insurance Company*_____

*Insurance Address*_____
Street *City/State/Zip Code*

*Name of Policy Holder*_____
Last *First* *Middle*

Social Security No. _____ *Birth date*_____

Employer _____ *Group No.* _____

Employer Address _____
Street *City/State/Zip Code*

Employer Phone _____ *Relationship to Patient* _____

Continued >

Emergency Information

Contact's Name _____ *Relationship*_____

Address _____
Street *City/State/Zip Code*

*Home Phone*_____ *Work Phone*_____

Getting to Know You

*Is another member of your family a patient of our practice? Name*_____

When was your last dental visit? _____

*When was the last time you had a complete set of dental x-rays?*_____

Former Dentist _____
Name *Address* *Phone*

Why did you select our office? _____

We are very pleased to meet you, and look forward to meeting your friends and family.

For All Patients _____
Signature (Parent if Minor) *Relationship* *Date*