PITTSFORD SMILES DENTAL PC
GENERAL & SPECIALIZED DENTISTRY

Patient Acquaintance Form

Todays Date:_____

Name:_____ Birthdate:_____
Last First MI

How would you prefer to be addressed? _____ Gender:_____

_____
Address City State Zip Social Security #

Phone (cell / home/ work/ other) Alt Phone (cell / home/ work/ other) Email

How do you prefer to be contacted? ◯ Home ◯ Work ◯ Email Marital Status: ◯ Married ◯ Single ◯ Minor

Insurance Information

Minor Child: May need to complete both blocks for parent information Adults: Complete primary Insured Dual Coverage: complete secondary insured

◯ **I do not have insurance** Primary Insured: Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other:_____

Name:_____ Birthdate:_____
Last First MI MM/DD/YYYY

_____
Address City State Zip SS#

_____
Phone (cell / home/ work/ other) Alt Phone (cell / home/ work/ other) email

Dental Insurance Company Subscriber ID Group # Employer

Secondary Insured: Relationship to patient: ◯ Self ◯ Spouse ◯ Child ◯ Other:_____

Name:_____ _____ Birthdate:_____
Last First MI MM/DD/YYYY

_____
Address City State Zip SS#

_____
Phone (cell / home/ work/ other) Alt Phone (cell / home/ work/ other) email

Dental Insurance Company Subscriber ID Group # Employer

Emergency Contact & Relationship

_____
Name of Contact Your Relationship to Contact Person Phone #

_____
Address City State Zip

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Signature **Date** **State Driverse License #**