PDE center
PITTSFORD DENTAL EXCELLENCE
Elevating Dentistry to an Art Form

Patient Acquaintance Form

Name:_____ Date:_____
Last First MI

How do you prefer to be addressed?_____

_____
Address City State Zip Phone # Alt. #

Birthdate:_____ Email:_____
Month Day Year

Social Security #:_____ ◯ Married ◯ Single ◯ Minor ◯ Male ◯ Female

How do you prefer to be contacted? ◯ All Listed ◯ Home ◯ Work ◯ Email

Insurance Information

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

Primary Insured/ If no insurance, complete for responsible party

_____
Last First MI

_____
Street City State Zip

_____
Home Cell Email

_____
Birthdate (Mo/Day/Yr) Relationship to Patient

_____
Employer Dental Ins. Co.

_____
SS# Subscriber # Group#

Secondary Insured

_____
Last First MI

_____
Street City State Zip

_____
Home Cell Email

_____
Birthdate (Mo/Day/Yr) Relationship to Patient

_____
Employer Dental Ins. Co.

_____
SS# Subscriber # Group#

Emergency Contact & Relationship

_____
Name of Contact Your Relationship to Contact Person

_____
Address City State Zip Phone # Alt. #

Also, who can we thank for inviting you to our practice?_____
Name of person we can thank for referring you.

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for the 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 the dentist 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 of patient or responsible party Date State Driver's License #