JACOB GRAPEVINE DDS
SIGNATURE DENTISTRY

Patient Information

Patient Name: ____ Date: ________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________ Birth Date: _________________

Social Security #: ______________________ Driver's License # ________________ State__________

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home):_____________(Work): ______________ Ext: ______________ Cell :________________

E-Mail: _____________________ Fax:. ______________

Best time to call ____________Best way to contact you:___________ If Cell, may we text you ________________

Emergency Contact Name: **Phone:**

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Another Dental Office ☐ Website ☐ Work ☐ School ☐ Other

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: * ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____

Social Security #: ________________ Birth Date:_______ Driver's License # ________________________

Phone (Home):____________(Work): ____________ Ext: ________ Best time to call:__________________

Address: ____
Street Apartment #

____
City State Zip Code

*Financial responsibility lies with the patient, guardian, or parent who brings a child that receives treatment. We do not accept the responsibility for billing another parent or former spouse. Please be prepared to handle financial matters at the time of your visit.

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ___________________________ Occupation: ___________________________________

Address: ____
Street City State Zip Code