# Corinth Dental Care

**Tricia Halford, D.D.S.**

**PLEASE PRINT** **PATIENT INFORMATION**

**Last Name** **First Name** **Middle** **Name Called**

**Street Address** **Apt. #** **City** **State** **Zip Code**

**/ / / / M / F S M D W / /**

**Social Security Number** **Date of Birth** **Age** **Sex** **Marital Status** **Area Code/Phone**

**Employed By** **Spouse's Name** **Employed By**

**Employer's Address** **Spouse's Phone**

**/ / / /**

**Occupation** **Business Phone** **Occupation** **Business Phone**

**/ /**

**How did you hear about our practice?** **Your E-mail Address** **Your Cell Phone**

**What is your preferred method of communication? Email_____Text_____Both_____**

**Nearest Friend or relative not living with you?_____Phone_____**

## POLICYHOLDER OR FINANCIALLY RESPONSIBLE PERSON

☐ **Check here if same as patient & disregard this section**

Last Name First Name Middle Relationship to Patient

Street Address Apt. # City State Zip

/ / / / / /

Date of Birth Social Security # Area Code and Home Phone

/ /

Employer Area Code and Business Phone

## INSURANCE INFORMATION

☐ **Check here if you have brought your insurance id card and disregard this section.**

| | **Primary Insurance** | **Secondary Insurance** |
|---|---|---|
| Ins. Co. Name | | |
| Mailing Address | | |
| City, State, Zip | | |
| Area Code/Phone | | |

**METHOD OF PAYMENT: Check ☐ Cash ☐ Credit Card ☐**

SIGNATURE _____ DATE_____