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drsandihamm.com

1830 EAST BROAD STREET, SUITE 100

MANSFIELD TEXAS 76063

SANDI L. HAMM DDS  
COSMETIC & COMPREHENSIVE DENTISTRY



Date \_\_\_\_\_

1. **Patient's Name** \_\_\_\_\_ Preferred to be called \_\_\_\_\_  
Last First Middle

2. Address \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Street City State Zip

3. Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

4. E-Mail Address \_\_\_\_\_ Cell # \_\_\_\_\_

5. Employer \_\_\_\_\_

6. Occupation \_\_\_\_\_

7. Work Phone \_\_\_\_\_

8. **Person Responsible for Payment** \_\_\_\_\_  
Last First Middle

9. Address \_\_\_\_\_  
Street City State Zip

10. Relationship to Patient \_\_\_\_\_

11. Social Security # \_\_\_\_\_

(if minor, list parent's names:)

12. Birthdate \_\_\_\_\_

Father \_\_\_\_\_

13. Driver's License # \_\_\_\_\_

First Last

14. Home Phone \_\_\_\_\_

Mother \_\_\_\_\_

15. Employer \_\_\_\_\_

First Last

16. Work Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION TO ASSIST YOU IN FILING ELECTRONICALLY.**

17. Insured's Name (employee) \_\_\_\_\_

18. Insured's Birthdate \_\_\_\_\_

19. Insured's Address (if different from above) \_\_\_\_\_

20. Insured's Social Security # \_\_\_\_\_

21. Insured's Employer \_\_\_\_\_

22. Insurance Co. Name \_\_\_\_\_ Group Name \_\_\_\_\_

23. Insurance Address \_\_\_\_\_

**EMERGENCY INFORMATION**

24. Local Friend or Relative not living with you \_\_\_\_\_

25. Complete Address \_\_\_\_\_

26. Phone No. \_\_\_\_\_

**GETTING TO KNOW YOU**

27. Why did you select our office? \_\_\_\_\_

28. Whom may we thank for referring you? \_\_\_\_\_

29. Is another member of your family or relative a patient in our practice? \_\_\_\_\_

30. When was your last dental visit? \_\_\_\_\_

31. When was the last time you had complete dental X-rays taken? \_\_\_\_\_ Dentist: \_\_\_\_\_

**FOR ALL PATIENTS**

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services rendered by this office.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE