Arthur R. Kremer, DDS

Patient Information

Full Name ______________________________ Date ______________

Address ________________ City ____________ State ______ Zip ____________

Birthdate ____________ Male/Female Home Phone# (_____) ____________________

Cell Phone# (_____) __________ Work Phone# (_____) ____________________

How would you prefer we confirm your appointments? Phone Email Text Message

Email Address ______________________________

Marital Status: Single Married Divorced Widowed Minor

Social Security # ____________________

Employer ____________________ Occupation ____________________

Business Address ______________ City ____________ State ____ Zip ____________

How did you hear about our office or who can we thank for referring you? ____________________

Emergency Contact ____________________ Phone# (_____) ____________________

Responsible Party (if patient is a minor)

Name of person financially responsible for this account ____________________

Relationship to patient ____________________ Phone# (____) ____________________

Address of Employer ____________ City ____________ State ______ Zip ____________

Insurance Subscriber (☐ ***check here if subscriber is the patient and skip section)***

Name of Insured ____________________ Relationship to Patient ____________

Subscriber Birthdate ____________________ Subscriber Social Security # ____________

Employer ____________________ Occupation ____________________

Business Address ______________ City ____________ State ______ Zip ____________

Insurance Information

Insurance Co. ____________________ Group # ____________

Subscriber ID # ____________________

Insurance Company Address ____________________

City ____________________ State ____________ Zip ____________

Insurance Co. Phone # (____) ____________________

Do you have additional dental insurance? Yes No If yes, please complete the following.

Insurance Co. ____________________ Group # ____________

Subscriber ID # ____________________

Insurance Company Address ____________________

City ____________________ State ____________ Zip ____________

Insurance Co. Phone # (____) ____________________