PERSONAL CARE DENTISTRY
7046 Torresdale Avenue, Philadelphia, PA 19135
Phone: 215-335-4955

Patient Information

Patient Name:_____**Date**_____
Last First Middle

Gender:(M/F)_____Marital Status:_____Birth Date_____Social Security #_____

Address:_____
Street Apartment #

_____
City State ZipCode

Phone #'s: Home_____Cell_____Best time to call_____
Email:_____
How did you hear about us?(friend/family, internet, newspaper,etc)_____
Do you agree to have Information About Your Appointment Date, Time, and Status given via text messaging:
Yes_____ or No_____ If you prefer to use a number different than cell phone, list here:_____

Insurance Information/Payment Method

Do you have more than one Dental Insurance Plan? **Yes_____No_____**
Name of Primary Dental Insurance Plan:_____
*Name of the Policy Holder:*_____
Relationship to the Patient:(i.e. SELF, Mother, Father, Wife, Husband, etc.). If the patient and policyholder are the same person, put SELF._____
*Name of Employer:*_____
Policy Holder's Social Security Number:_____
Group Number:_____
Dental ID Number:_____

Name of Secondary Dental Insurance Plan:_____
Name of the Policy Holder_____
*Name of Employer:*_____
Policy Holder's Social Security Number:_____
Group Number:_____
Dental ID Number:_____

Payment Method:
Insurance:_____, Check_____, Cash_____, CreditCard(Visa/Mastercard)_____,CareCredit_____

All payment is due at the time of service.
Please present your insurance card to the receptionist. Thank you