FOX DENTAL ASSOCIATES
2 IRIS STREET
ASHEVILLE, NC 28803
(828) 252-2791

Thank you for selecting us for your dental care

PATIENT INFORMATION

Name:_____ Birth Date: _____ Social Security #:_____
Address: _____ City: _____ State: _____ Zip: _____
Gender ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Minor Email: _____
Home Phone #: (_____)_____ Cell #: (_____) _____ Other Phone #: (_____)_____
Occupation:_____ Employer: _____ Work Phone #: (_____)_____
Work Address: _____
Are you a student? ☐ Yes ☐ No ☐ Full time ☐ Part time School Name: _____
Spouse Name: _____ Occupation: _____ Phone #: (_____)_____
Person to contact in case of emergency:_____ Phone #: (_____)_____
Whom may we thank for referring you?_____

INSURANCE INFORMATION

Name of insured:_____ Relation to patient: _____
Birthday:_____ Social Security #:_____ Currently a patient in our practice? ☐ Yes ☐ No
Employer: _____ Work Phone #: (_____)_____
Insurance Company:_____ Group #: _____ Union or Local #: _____
Insurance Co. Address: _____ Phone #: (_____) _____
Annual deductible amount? _____ Maximum annual benefit? _____ Insurance benefits used this year? _____

SECONDARY INSURANCE INFORMATION

Name of insured:_____ Relation to patient: _____
Employer: _____ Birthday: _____ Social Security #: _____
Insurance Company:_____ Group #: _____ Union or Local #: _____

RESPONSIBLE PARTY

(Must complete if patient is under 18 or full time student)

Name of person
responsible for this account: _____ Relation to patient: _____
Address: _____ Phone #: (_____) _____
Birthdate: _____ Currently a patient in our practice? ☐ Yes ☐ No Email: _____
Employer: _____ Work Phone #: (_____) _____

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date