1322 E. Washington Street (Downtown)
Greenville, SC 29607
(864) 235-1200 Fax (864) 235-2512
downtown@rockycreekdental.com

978 Batesville Road (Eastside)
Greer, SC 29651
(864) 675-9399 Fax (864) 675-1134
eastside@rockycreekdental.com

ROCKY CREEK
DENTAL CARE

First: _____ Last: _____ Middle Initial: _____

Preferred name: _____ Minor ____ Single ____ Married ____ Male ____ Female ____

Address: _____ _____ _____ _____
Apt # City State Zip

Home# _____ Work# _____ Cell# _____

DOB: ____/____/____ SS#_____ E-Mail:_____

How did you hear about us? _____

Person Responsible for Account **(if different from patient)* _____

Currently a patient in our office? ____ Yes ____ No Relationship to you: _____

Address **(if different from patient)* _____

If Patient is a Minor Parent/Guardian Status: Single__ Married__ Divorced__ Separated__ Foster__ Other___
Child lives with: Parents__ Mother__ Father__ Grandparents__ Foster Parents__ Other_____
If divorced, are there court documents that require either parent to carry insurance on child? Yes____No____
(please provide documentation)
If divorced, who has primary custody? _____

DENTAL INSURANCE (Primary)

Policy Holder: _____ *DOB: ____/____/____ ID# _____

EMPLOYER: _____ **(if different from patient)* *SS# _____

Insurance Co. _____ Insurance Co. Phone #: _____

Additional Dental Insurance (Secondary)

Policy Holder: _____ *DOB: ____/____/____ ID# _____

EMPLOYER: _____ **(if different from patient)* *SS# _____

Insurance Co. _____ Insurance Co. Phone #: _____

Emergency Contact: _____ **Phone#**_____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover at the time of service. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Patient or Responsible Party **Date** ____/____/____