

Southern Edge Dental Center-FairFax  
1987 Allendale-Fairfax Highway  
FairFax, SC 29827

(803) 632-3301

*Thank you for trusting us with your dental care.  
We promise to do our best to provide you with  
the finest care available. If you have any  
questions please do not hesitate to call us.*

Patient # \_\_\_\_\_

Date \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Home Phone # ( ) \_\_\_\_\_ Cell Phone #1 ( ) \_\_\_\_\_ Cell Phone #2 ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

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

Person to contact in case of emergency \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### RESPONSIBLE PARTY

Name of Person  
Responsible for this Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Birthdate \_\_\_\_\_ Currently a patient in our office?  Yes  No

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

### INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

### ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

