

  
**CANYON DENTAL**  
JOSEPH R. SCHMIDT DDS

**Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile #: \_\_\_\_\_ Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: M / F      Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      SS#: \_\_\_\_\_

Family Status (circle): Single Married Divorced Child      Spouse's Name: \_\_\_\_\_

How did you first hear about our office? (circle one): Word of mouth - Drive by - Internet - Insurance website

Whom may we thank for referring you to our practice? \_\_\_\_\_

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

Emergency contact? Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

**Person Responsible for Account (responsible party, if someone other than the patient)**

Name of responsible party: \_\_\_\_\_

Relationship to patient (Circle): Self Spouse Parent Other: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile #: \_\_\_\_\_ Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      SS#: \_\_\_\_\_      Email: \_\_\_\_\_

**Primary Insurance**

Name of Insured: \_\_\_\_\_ Relationship to Insured(circle one): Self Spouse Child Other

Insured SS#: \_\_\_\_\_ Insured Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Secondary Insurance**

Name of Insured: \_\_\_\_\_ Relationship to Insured(circle one): Self Spouse Child Other

Insured SS#: \_\_\_\_\_ Insured Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_