# *H. Carl Burton, Jr., D.M.D.*

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Greenville, SC 29615
(864) 627-1010

## *PATIENT INFORMATION RECORD*

Name_____ Age_____ Birth Date_____
Home Address_____ Home Phone:_____ Soc Sec # _____
_____ Zip Code_____
Email_____ Cell Phone _____
Your Occupation:_____ Company _____
Business Address_____ Business Phone _____
Physician_____
Previous Dentist:_____ City: _____
Who referred you to us?_____
Husband or Wife's name:_____
Husband or Wife's Occupation_____
In Case of Emergency Contact:_____ Phone # _____

## *RESPONSIBLE PARTY INFORMATION*

(Complete only if different from Patient)

Name_____ Date of Birth_____
Address _____ Soc Sec #_____
_____ Zip Code_____
Home Phone_____ Work Phone_____
Cell Phone_____ Email_____
Responsible Party Relationship to Patient ____ Self ____ Spouse ____ Parent ____ Child ____ Other

## *INSURANCE INFORMATION*

We will gladly file your dental insurance for you. We file our claims electronically. This speeds payment of your claim. Please note that you are responsible for any balance not paid by your insurance carrier. Please allow us to copy your insurance card.

Insured's Name _____ Insured Date of Birth _____
Address _____ Insured Soc Sec # _____
_____ Insured's Relation to Patient
Insured's Employer _____ ____Self ____Spouse ____Child ____Other
Employer Address _____ Work Phone _____

**Signature:** _____

**DENTAL INSURANCE** **Name Carrier** _____
**Address** _____
**Group Number**_____ **Group I.D. Number** _____
**NOTE: Group Number and Group I.D. Number is important information needed for your claim.**

Thank you for completing all information needed for your records with our office.