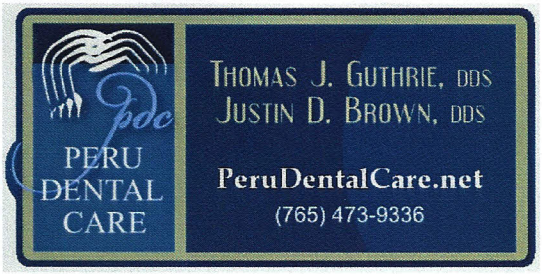

Peru Dental Care
5 Logan Street
Peru, Indiana 46970

Patient Information Update (Confidential)

Name_____ Date_____

Soc. Security # _____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Check the Appropriate Line: _____Minor _____Single _____Married _____Divorced _____Widowed

If Student – Name of School/College_____ Full Time_____ Part Time_____

Patient's or Parents Employer _____ Work Phone _____

Spouse or Parents Name _____ Employer _____ Work Phone_____

Emergency Contact _____ Phone_____

Whom May We Thank for Referring You? _____

Responsible Party (if different from above or patient is a minor)

Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Birthdate_____ Employer_____ Work Phone_____ Soc. Sec#_____

Is this person currently a patient in our office? _____Yes _____No

Primary Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Birthdate_____ Soc. Sec#_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Employer address_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____ Policy /ID#_____

Insurance Company Address_____ City_____ State_____ Zip_____

How much is your Deductible?_____ How much have you used?_____ Max Annual Benefit_____

Do you have Additional Insurance? _____Yes _____No

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Soc. Security #_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Employer address_____ City_____ State_____ Zip_____

Insurance Company_____ Group#_____ Policy /ID#_____

Insurance Company Address_____ City_____ State_____ Zip_____

How much is your Deductible?_____ How much have you used?_____ Max Annual Benefit_____