

# Patient Information Sheet



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

Full Name: \_\_\_\_\_

First

Middle

Last

Please address me as \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Family Members who are patients in our office: \_\_\_\_\_

In case of Emergency, Please contact: \_\_\_\_\_ Phone Number \_\_\_\_\_

**The following block of information pertains to the person(s) who are Financially Responsible for this account. You do not need to duplicate the information given above.**

Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Primary Dental Insurance Company \_\_\_\_\_ Group or Certificate # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Employer Name & Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Position \_\_\_\_\_ How Long Employed? \_\_\_\_\_ Social Security Number \_\_\_\_\_

Secondary Dental Insurance Company \_\_\_\_\_ Group or Certificate # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Employer Name & Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Position \_\_\_\_\_ How Long Employed? \_\_\_\_\_ Social Security Number \_\_\_\_\_

**I understand that all services must be paid for when treatment is rendered unless prior arrangements have been made. Insurance payments will be credited when received.**

Signature \_\_\_\_\_ Date \_\_\_\_\_