PATIENT INFORMATION

Date_____ Social Security #_____

Patient Name _____
Last Name First Name Middle Initial

Address_____

City _____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthday_____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Patient Employer/School_____ Occupation_____

How did you hear about us? ☐ Website ☐ Phonebook ☐ Current Patient _____ ☐ Other_____

Home Phone (_____)_____ Cell Phone (_____)_____ Text ☐ Yes ☐ No

Work Phone _____Ext._____ Email_____

Best # to reach you between 5:30pm – 7:30pm_____ Confirm appointments by email? ☐ Yes ☐ No

In case of Emergency, Contact: Name_____Relationship_____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient_____Birthdate_____ SS#_____

Address (if different than patient)_____

City _____ State_____ Zip_____

Primary Insurance Employer_____ Dental Insurance Company_____

Group/Plan #_____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address(if different than patient)_____

City _____ State_____ Zip_____

Secondary Insurance Employer_____ Secondary Dental Insurance Co._____

Group/Plan #_____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____