PATIENT / INSURANCE INFORMATION

Rev 02/20/2015

Patient Information

Patient Name _____ Date _____
Last First Middle

Preferred Name _____ Birthdate _____ SS # _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Email _____

How did you hear about our office? _____ General Dentist _____

Responsible Party Information

Primary Contact Name _____
Last First Middle Relationship to Patient

Mailing Address _____
Street City State Zip

Years at this Address _____ SS # _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____ # Years Employed _____

Secondary Contact Name _____
Last First Middle Relationship to Patient

Employer _____ Occupation _____ # Years Employed _____

Mailing Address _____
Street City State Zip

Years at this Address _____ SS # _____ Date of Birth _____

Dental Insurance Information

Primary Insured Name _____ ID # _____

Insurance Company _____ Group # _____ Local # _____

Company Address _____
Street City State Zip

Do you have dual coverage? Yes ☐ No ☐ If yes:

Secondary Insured Name _____ ID # _____

Insurance Company _____ Group # _____ Local # _____

Company Address _____
Street City State Zip

Emergency Contact Information

Name of person you wish to have contacted in case of emergency _____

Complete Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

I certify the above to be true and correct to the best of my knowledge.

_____ _____ _____ _____ _____

Signature (Parent's signature if patient is a minor)

Updates (date & initial)