PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: ____/_____/_____

Sex: _____ Age: ____ Birth Date: _____/_____/_____ Soc. Sec. #: _____

Single: _____ Married: _____ Height: _____ Weight: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell: _____

Employer: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

Responsible Party's Name: _____ Birth Date: _____/_____/_____

Soc. Sec. #: _____ Drivers License # _____Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Nearest Relative (not living with you): _____

Address: _____ Relationship to Patient: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Physician: _____ Referring Dentist: _____ Orthodontist: _____

Pharmacy Name: _____ Pharmacy Location: _____

Reason for Visit: _____

Family members who have been patients here: _____

Do you have insurance: YES _____ NO _____

Please complete reverse side

PATIENT INSURANCE INFORMATION

Primary Insurance

Name of Dental Insurance Plan: _____ Phone Number: _____

Cardholder's Name: _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. #: _____

Name of Medical Insurance Plan: _____ Phone Number: _____

Cardholder's Name: _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. #: _____

Secondary Insurance

Name of Dental Insurance Plan: _____ Phone Number: _____

Cardholder's Name: _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. #: _____

Name of Medical Insurance Plan: _____ Phone Number: _____

Cardholder's Name: _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. #: _____