PATIENT AND INSURANCE FORM

Date: ____________

First Name: ________________________ Middle Initial: _____ Last Name: _______________________ Preferred Name: ______________

Address: ____ City: ______________________ State: _______ Zip: _________

Birth Date: ________________ Gender: ____Male _____ Female Social Security #: _________________________

May we send text and/or email messages? ____Yes ____ No

Home Phone: _______________________ Cell Phone: _________________________

E-Mail Address: _______________________________________

Employer: _________________________ Work Phone: _____________________

Marital Status: ___Minor ___ Single ___ Married ___Widowed ___ Divorced ___ Engaged ___Domestic Partnership

Referred by: Search engine: ____________________Website: ____________________ or other: ________________________________

SPOUSE'S INFORMATION ____ Not Applicable

Name: ___________________________________ Birth Date: ______________ Social Security Number: ___________________

Phone Number: _______________________ May we share your protected health information with your spouse? ___ Yes ___ No

May we link your account with your spouse's? ___ Yes ___ No

PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Mother's First Name: __________________________ Middle Initial: ________ Last Name: ____________________________

Address: _____________________________________ City: ________________________________ State: _______ Zip: __________

Home Phone: ____________________________ Cell Phone: _____________________________

Father's First Name: __________________________ Middle Initial: ________ Last Name: ____________________________

Address: _____________________________________ City: ________________________________ State: _______ Zip: __________

Home Phone: ____________________________ Cell Phone: _____________________________

**I understand that by signing below I am financially responsible for the patient listed at the top of this form*

Signature: ____ Date: ___________________

PRIMARY DENTAL INSURANCE

Insurance Company: __________________________________ Group #: ______________________ ID #: ______________________

Insured Name: _____________________________________ Insured Birth Date: _________________________

Insured Social Security Number: _________________________________ Employer: ________________________________

SECONDARY DENTAL INSURANCE

Insurance Company: __________________________________ Group #: ______________________ ID #: ______________________

Insured Name: _____________________________________ Insured Birth Date: _________________________

Insured Social Security Number: _________________________________ Employer: ________________________________