Family Patient Information

Patient Name: _____ **Date**: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security #: _____ **Birth Date**:_____ Email _____

Children (on account): _____ Birth Date:_____ ☐ Male ☐ Female
_____ Birth Date:_____ ☐ Male ☐ Female
_____ Birth Date:_____ ☐ Male ☐ Female
_____ Birth Date:_____ ☐ Male ☐ Female
_____ Birth Date:_____ ☐ Male ☐ Female

Phone (Home):_____ (Work): _____ Ext:_____ (Cell):_____

Address: _____
Street Apt City State Zip

Name of Nearest Relative Not Living With You _____ Phone _____

Spouse Information (*or* Person Responsible for Account)

Please check here if spouse is: ☐ the person responsible for account/payment

Name:_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Address: _____
Street Apartment # City State Zip

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone Number: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

Primary Dental Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ **SS #**: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:_____

Secondary Dental Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ **SS #:** _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

***Insurance Plan Name and Address*:** _____

Whom may we thank for referring you to our practice? _____