PATIENT INFORMATION

Patient Name: _____ Date: _____
(Last) (First) (M.I.)

Social Security _____ Birth Date: _____ Age: ____ Gender _____ ○ Married | ○ Single | ◉ Other

Phone (Home): _____ Phone (Work): _____ Spouce Name: _____

Address: _____
Street Apt #

_____
City State Zip Code

Dentist: _____ Physician: _____

RESPONSIBLE PARTY INFORMATION *(if different from patient)*

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ *Ext.* _____

Employer: _____

INSURANCE INFORMATION

Primary Dental Insurance:

Insurance Plan Name: _____ Address: _____

Name of Subscriber: _____ Is subscriber a patient here? ○ YES ○ NO

Subscriber Birthdate: _____ ID# or SS# _____ Group# _____

Subscriber's address: _____ Subscriber's Employer: _____

Insurance Plan Phone #: _____ Relationship to patient: ○ SELF ◉ SPOUSE ○ PARENT

OTHER: _____

Secondary Dental Insurance:

Insurance Plan Name: _____ Address: _____

Name of Subscriber: _____ Is subscriber a patient here? ○ YES ○ NO

Subscriber Birthdate: _____ ID# or SS# _____ Group# _____

Subscriber's address: _____ Subscriber's Employer: _____

Insurance Plan Phone #: _____ Relationship to patient: ○ SELF ○ SPOUSE ○ PARENT

OTHER: _____

OFFICE USE ONLY!

Rep: _____ Max: _____ Ded: _____ per _____

Prev: _____ Basic: _____ Major: _____ Intls. _____