PATIENT INFORMATION

(PLEASE COMPLETE IN INK)

PATIENT

*1.Patient's Name:_____

*2.Address:_____

(No P.O. Box, Give Street address)

City:_____

State:_____Zip:_____

*3.Previous Address:_____

(If above less than 1 yr) City:_____

State:_____Zip:_____

4.Phone: H_____W_____

Cell_____

*5. Date of Birth:_____

*6.Employer:_____

(Business Name if Self Employed)

Address:_____

City:_____State:_____

*7.Social Security No:_____-_____-_____

8.Whom may we thank for referring you?

Name:_____

9.Check one: Married____Single____

Separated____ Widowed_____

PATIENT'S SPOUSE, PARENT OR GUARDIAN

*10.Patient's Name:_____

11.Address_____

(No P.O. Box, Give Street address)

City:_____

State:_____Zip:_____

*12.Previous Address_____

(If above less than 1 yr) City:_____

State:_____Zip:_____

13.Phone H:_____W_____

Cell_____

*14.Date of Birth:_____

*15.Employer:_____

(Business Name if Self Employed)

Address:_____

City: _____State:_____

*16.Social Security No:_____-_____-_____

17.Covered by Dental Insurance? Yes____No____

If your answer is yes, complete information below

* Indicates numbers that must be completed

INSURANCE INFORMATION

Patients with insurance are responsible for payment of their bills. We do not have contracts with insurance carriers. It is not always possible to predict which services the carrier covers or how much they will pay for a particular service. The Dental Group will assist you in every way possible with your insurance carrier.

	First Insurance Co.	Second Insurance Co. (If covered by more than one insurance)
1. Employee's Name	1. _____	1. _____
2. Employee's Social Security No.	2._____-_____-_____	2._____-_____-_____
3. Employee's Sex	3.Male_____Female_____	3.Male_____Female_____
4. Employee's Date of Birth	4._____	4._____
5. Insurance Co. Name	5._____	5._____
6. Insurance Co. Address	6._____ City_____ State:_____ Zip:_____	6._____ City_____ State:_____Zip:_____
7. Group Plan #	7._____	7._____
8. Local Union #	8._____	8._____
9. Policy # (or P.O.E.#)	9._____	9._____
10. Employer's Name	10._____ (Business Name if Self Employed)	10._____ (Business Name if Self Employed)
11. Employer's Address	11._____ City_____ State:_____Zip:_____	11._____ City_____ State:_____Zip:_____
12. Family Members Covered	12._____- _____ NAME BIRTHDATE _____-_____ _____-_____	12._____-_____ NAME BIRTHDATE _____-_____ _____-_____