PATIENT INFORMATION

DATE: ________________ **Have you been a patient in our office before? Yes No**

PATIENT:

Miss Ms. Mrs. Mr. Dr. ____

First Middle Last

I prefer to be called: _____________________ Male Female Birthdate: ____/____/____ Age: ____

SS#: _____/_____/________ Drivers Lic. #:____________________ State: ______

Home Address: ______________________________ City: ________________ State: ____ Zip: _______

Home Phone #: ( )_____-________ Cell#: ( )_____-________ Work #:( )____ -______X_____

Employer: ___________________ Address: _____________________________ Occupation: ___________

FINANCIAL RESPONSIBLE PARTY: (If other than patient and/or patient is under the age of 18)

Miss Ms. Mrs. Mr. Dr. ____

First MI Last

Relationship to patient : Parent Spouse Legal guardian Other ______________________________

Home address: ______________________________ City:____________________St:____ Zip: ________

Home Phone: ( )_____-________ Cell #: ( )_____-_________ Wk #: ( )_____-______ X_____

Drivers Lic. #: ______________________ State: _____Birthdate ___/___/___SS#: _____-_____-______

Employer: _______________________ Wk Address: ____

Other Responsible Party: Miss Ms. Mrs. Mr. Dr. ____

Home address: __________________________________City: _______________ St.: ______ Zip: ______

Home Phone#: ( )_____-_________ Cell #: ( )_____-_________ Wk #:
( )___________X_____

Drivers Lic. #: ______________________ State: _____ SS#: _______-____-___________

Employer: _______________________ Wk Address: ____

DENTIST/PHYSICIAN INFORMATION:

Whom may we thank for referring you to us? ____

Name of Dentist: ___________________________D.D.S. Address:______________________________

City: ____________________________________ St: ____ Zip:________ Phone: ( )_____-_________

Orthodontist: _______________________________ D.D.S. Address: ______________________________

City: ____________________________________ St: ____ Zip: ________ Phone: ( )_____-_________

Name of Physician: __________________________ M.D. Address: ______________________________

City: ____________________________________ St: ____ Zip: ________ Phone: ( )_____-_________

INSURANCE INFORMATION

PLEASE NOTE: *AN INSURANCE POLICY IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY, NOT BETWEEN THE DOCTOR AND THE INSURANCE COMPANY. WE ARE PLEASED TO COMPLETE ALL PAPERS NECESSARY FOR YOUR CLAIM. HOWEVER, PLEASE BE AWARE THAT FINANCIAL RESPONSIBILITY REMAINS WITH THE PATIENT.*

DENTAL INSURANCE

Primary Insurance Co.:____
Billing address: ______________________________ City: _________________ St.:____ Zip: ______
Telephone: (   )______-_______________Group #: ___________ Group Name: ______________
Subscriber Name: _____________________________ SS#: ______-____-_________
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: ____________________________ Address: _________________________________

Secondary Insurance Co.:____
Billing address: ______________________________ City: _________________ St.:____ Zip: ______
Telephone: (   )______-______________Group #: ___________ Group Name: ______________
Subscriber Name: _____________________________ SS#: ______-____-_________
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: ____________________________ Address: _________________________________

MEDICAL INSURANCE

Primary Insurance Co.:__________________________________ HMO: Yes No
Billing address: ______________________________ City: _________________ St.:____ Zip: ______
Telephone: (   )______-_____________Group #: ___________ Group Name: ______________
Subscriber Name: _____________________________ SS#: ______-____-_________
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: ____________________________ Address: _________________________________

Secondary Insurance Co.:_________________________________ HMO: Yes No
Billing address: ______________________________ City: _________________ St.:____ Zip: ______
Telephone: (   )______-______________Group #: ___________ Group Name: ______________
Subscriber Name: _____________________________ SS#: ______-____-_________
Subscriber date of birth: ____/___/____ Relationship to patient: self spouse parent other
Employer name: ____________________________ Address: _________________________________

STUDENT STATUS

Is the patient a full time student? Yes No
School attending: _________________________ Address: _____________________________________
Have you updated this information with your insurance company this semester? Yes No