Patient Insurance Information

Patient Name: ______ Date: ______ Email address: ______
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Separated ☐ Child ☐ Have children How many ____ Age(s) ______

______ Date of birth: ______ Phone: ______
Social Security number month/day/year home work mobile

Address: ______
Street Apartment # City State Zip code

Employer: ______ Driver's License #: ______

Referral Information

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

☐ Friend ☐ Relative ☐ Co worker
☐ Yellow pages ☐ Another dental office
☐ Online ☐ School ☐ Other

Responsible Party Information

Name of person responsible for this account: ______ Relationship to patient: ______

Address: ______
Street Apt. # City State Zip code

Employer: ______ Driver's License #: ______ Date of birth: ______

Social Security #: ______

Phone: ______
home work mobile

Insurance Information

Primary

Primary Insurance:

Name of Insured: ______ Birth date: ______ Relationship to patient: ______
Last First MI

Insured's Address: If same check here ☐ ______
Street City State Zip code

Insured's Employer: ______ ID#: ______ Group #: ______

Address: ______
Street City State Zip code

Insurance Plan Name and address: ______

Secondary

Secondary Insurance:

Name of Insured: ______ Birth date: ______ Relationship to patient: ______
Last First MI

Insured's Address: If same check here ☐ ______
Street City State Zip code

Insured's Employer: ______ ID#: ______ Group #: ______

Address: ______
Street City State Zip code

Insurance Plan Name and address: ______

Person to contact in case of an emergency ______

Phone: ______
home work cell