

PATIENT INFORMATION

Patient's Name: _____ Today's Date: _____

Name Patient Prefers to Be Called _____

Patient's Marital Status: Single Married Separated Divorced Widow Widower

Sex: _____ Age: _____ Birth Date: _____ Soc. Sec. # _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Pager: (____) _____

Full Time Student? Yes No If yes, Name and Address of School _____

Spouse or Parent(s) Name: _____

Responsible Party's Name: _____ Relationship to Patient: _____

Address: _____ Soc. Sec. # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone (____) _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (**address and phone other than that already listed**)

Name: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____

Reason for Visit: _____

Physician: _____ Dentist: _____

Orthodontist: _____ Referred by: _____

Have we seen you or any of your family members or friends? If so, please list name and address: _____

Method of Payment (Please Check)

- Cash/Check CareCredit
 Visa Mastercard

PATIENT INSURANCE INFORMATION

We are committed to helping you maximize your insurance benefits and we will gladly file insurance claims as a courtesy to our patients. However, due to the complexities of insurance contracts we can not guarantee insurance coverage and/or payment. So that we may assist you in filing your insurance, please provide us with the information requested below. All information is kept confidential.

PRIMARY INSURANCE

Insured's (Employee's) Name: _____ Insured's Birth Date: _____
Patient's Relation to Insured: Self Spouse Child Other _____
Insured's (Employee's) Employer: _____ Employer Address: _____
Name of Insurance: _____ (please circle type of coverage) Medical/Dental
Insurance Co. Address: _____ Ins. Co. Phone: _____
Contract/Policy/ID #: _____ Group #: _____

SECONDARY INSURANCE

Insured's (Employee's) Name: _____ Insured's Birth Date: _____
Patient's Relation to Insured: Self Spouse Child Other _____
Insured's (Employee's) Employer: _____ Employer Address: _____
Name of Insurance: _____ (please circle type of coverage) Medical/Dental
Insurance Co. Address: _____ Ins. Co. Phone: _____
Contract/Policy/ID #: _____ Group #: _____

THIRD INSURANCE

Insured's (Employee's) Name: _____ Insured's Birth Date: _____
Patient's Relation to Insured: Self Spouse Child Other _____
Insured's (Employee's) Employer: _____ Employer Address: _____
Name of Insurance: _____ (please circle type of coverage) Medical/Dental
Insurance Co. Address: _____ Ins. Co. Phone: _____
Contract/Policy/ID #: _____ Group #: _____