

Getting To Know You

Date: _____

First Name _____ Middle Initial _____

Last name: _____

Patient is (check all that apply) ___ Policy Holder ___ Responsible party

Patient information: ___ male ___ female

Address: _____ City _____ State _____ Zip _____

Home phone: _____ Work # _____ ext. _____ Cell# _____

Marital status: ___ married ___ single ___ divorced ___ separated ___ widowed

Birthdate: _____ age _____ Social Sec. # _____ - _____ - _____

Email: _____ Emergency #/name: _____

Employment: ___ fulltime ___ part time ___ retired

If student status: ___ fulltime ___ part time

Primary Insurance Information:

Insured name: _____ Relation to patient: ___ self ___ spouse ___ child ___ other

Employer: _____ Employer address _____

Employer City, State, Zip _____

Ins. Company: _____ Ins. Co. Address: _____

Ins. Co. City, State, Zip: _____

Responsible Party (if someone other than the patient):

First Name: _____ Last Name: _____ Initial _____

Address: _____ City: _____ State _____ Zip _____

Home #: _____ Work #: _____ ext _____ Cell# _____

Birthdate: _____ Social Sec. #: _____ - _____ - _____

Responsible party is also a ___ Policy holder for patient
 ___ Primary Insurance Policy Holder
 ___ Secondary Insurance Policy Holder

Insurance Information

All charges are the patient's responsibility. Our office will be happy to assist you in filing your claims on your dental insurance. Please give any pertinent information to the receptionist.

Methods of payment are: Cash, Check, Mastercard, Visa, and Discover

Who may we thank for referring you to our office? _____

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