

FINANCIAL INFORMATION

PATIENT

PATIENT LAST NAME		FIRST		MIDDLE	TODAY'S DATE	
BIRTH DATE MM/DD/YR		SOCIAL SECURITY NUMBER			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	
HOME PHONE <input type="checkbox"/> NONE		CELL PHONE			<input type="checkbox"/> YES, PERMISSION TO LEAVE MESSAGES ON PHONE	
MAILING ADDRESS				CITY	STATE	ZIP CODE
HOME ADDRESS <input type="checkbox"/> SAME		APT.		CITY	STATE	ZIP CODE
EMAIL ADDRESS:						
EMPLOYER <input type="checkbox"/> SELF <input type="checkbox"/> NONE <input type="checkbox"/> RET		BUSINESS ADDRESS		BUS. PHONE	OCCUPATION	
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU		RELATIONSHIP	PHONE ()	ADDRESS		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?					RELATIONSHIP	

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO		SCHOOL ATTENDING		CITY	GRADE
BOTH PARENTS NAMES					
PARENTS MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP			IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa FINANCIAL CUSTODY? <input type="checkbox"/> Mo <input type="checkbox"/> Fa		

FINANCIAL RESPONSIBILITY

IF SELF, CHECK HERE AND SKIP TO NEXT SECTION

PERSON RESPONSIBLE LAST NAME		FIRST		MIDDLE	RELATIONSHIP	
PHONE		SOCIAL SECURITY NUMBER			DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS <input type="checkbox"/> SAME AS ABOVE				CITY	STATE	ZIP CODE
EMPLOYER <input type="checkbox"/> SELF <input type="checkbox"/> NONE <input type="checkbox"/> RET		BUSINESS ADDRESS		BUS. PHONE	OCCUPATION	

PRIMARY DENTAL INSURANCE NONE PA, MEDICAID, WELFARE

INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.		SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.		GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	

SECONDARY DENTAL INSURANCE NONE

INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.		SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.		GROUP NO.	GROUP NAME		RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	