THE ASHBROOK CENTER FOR DENTISTRY

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____

Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder ☐

Patient Information

Address: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Security: _____

E-Mail: _____ ☐ I would ☐ would not like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Section 3

Emergency Contact: _____

Phone: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Section 2

Employer: _____

Address: _____

City, State, Zip: _____

Section 3

Ins. Company: _____

Address : _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Section 2

Employer: _____

Address: _____

City, State, Zip: _____

Section 3

Ins. Company: _____

Address : _____

City, State, Zip: _____