FAMILY DENTAL CENTER

(Please Print Clearly)

PATIENT INFORMATION

Patient's Last name: First: Middle: Preferred Name:

Sex: ❑ Male ❑ Female | Family Status: Single / Married / Child / Other | Birthday: / / | Social Security No.:

Street Address: Apt: City:

State: Zip Code: E-mail:

Home No.: ( ) | Mobile No.: ( ) | Work No.: ( ) Ext.

How were you referred to our office (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Groupon #_____

❑ Family ❑ Friend ❑ Close to home/work ❑ Google ❑ Other Name of person:

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Phone no.: ( )

RESPONSIBLE PARTY

❑ Self ❑ Spouse ❑ Person responsible for payment

Name: | Sex: ❑ Male ❑ Female | Birth date: / / | Social Security No.:

Address (if different): Employer: Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

DENTAL INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Cigna ❑ Delta Dental ❑ BCBS ❑ Met Life ❑ Aetna ❑ United Concordia ❑ United Healthcare ❑ Geha ❑ Guardian ❑ Other

Subscriber's name: | Subscriber's SSN.: | Birth date: / / | Policy No. | Group No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate secondary insurance (if applicable): ❑ Cigna ❑ Delta Dental ❑ BCBS ❑ Met Life ❑ Aetna ❑ United Concordia ❑ Geha ❑ Guardian ❑ United Healthcare ❑ Other

Subscriber's name: Subscriber's SSN: Birth date: / / Policy No. Group No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other