Demographic & Insurance Form

Patient Demographics:

Patient's Legal Name: ____ Preferred Name: ________________________

Birthdate: _______ /_______/________ Age: _______

Address: ____

Home/Cell Phone: ___________________________________ Email: ____

Employer: ______________________________ Occupation: ___________________________ Work phone: _______________

SSN: ____________________________________ Marital status: ___________________

Responsibility for Account: (skip if patient listed above is the one responsible for account)

Person responsible for account: ____________________________________ Relationship to patient: _____________________

Birthdate: ______________ SSN: ____________________________________

Address: ____

Home/Cell Phone: ___________________________________ Email: ____

Employer: ______________________________ Occupation: ___________________________ Work phone: ______________

Emergency Contact Information:

Emergency contact name:____________________________________ Relationship to patient: ________________________

Phone number:__________________________

Medical/Dental Providers:

Referred by: ____ Phone: ______________________

Primary Care Physician: _________________________________ Phone: ______________________

General Dentist: ______________________________________ Phone: ______________________

Orthodontist: ____ Phone: ______________________

Other provider: ______________________________________ Phone: _____________________

Pharmacy information:

Pharmacy Name and location: ____

Phone: ______________________________________

Demographic & Insurance Form

Patient's Name ____________________________________ Date of Birth ________/_________/___________

Primary MEDICAL Insurance:

Insurance Company Name: ________________ Telephone: ___________

Primary Insured's Name: _____________ Birth Date: _____ SSN:_____________

Employer's Name _____________________

Group #: _____________________ Policy/I.D. #: ________________

Relationship to Patient: _______________________

Secondary MEDICAL Insurance: (if applicable)

Insurance Company Name: ________________ Telephone: ___________

Primary Insured's Name: _____________ Birth Date: _____ SSN:_____________

Employer's Name _____________________

Group #: _____________________ Policy/I.D. #: ________________

Relationship to Patient: _______________________

Primary DENTAL Insurance:

Insurance Company Name: ________________ Telephone: ___________

Primary Insured's Name: _____________ Birth Date: _____ SSN:_____________

Employer's Name _____________________

Group #: _____________________ Policy/I.D. #: ________________

Relationship to Patient: _______________________

Secondary DENTAL Insurance: (if applicable)

Insurance Company Name: ________________ Telephone: ___________

Primary Insured's Name: _____________ Birth Date: _____ SSN:_____________

Employer's Name _____________________

Group #: _____________________ Policy/I.D. #: ________________

Relationship to Patient: _______________________