WATERS FAMILY DENTISTRY

PATIENT INFORMATION SHEET **Date:** _____

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Would you like email or text reminders for your upcoming appointments? YES/NO

Patient or Parent/Guardian Employer_____ Work Phone: _____

Spouse's Name: _____

Spouse's Employer: _____ Work Phone: _____

Person to contact in case of an emergency: _____ Phone: _____

Who may we thank for referring you? _____

RESPONSIBLE PARTY (PARENT OR INSURANCE POLICY HOLDER):

Name of Person Responsible for this Account: _____ DOB: _____

Relationship to Patient: _____ Phone: _____ SSN: _____

Is this person a current patient? YES/NO

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Date Employed: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Group #: _____ Policy #: _____

Claims mailing address: _____

Do you have additional (secondary Insurance? YES/NO **If yes, complete the following:**

Name of Policy Holder: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Date Employed: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Group #: _____ Policy #: _____

Claims mailing address: _____