

## PATIENT INSURANCE INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

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Patient's Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Referred by: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Family members who have been patients here: \_\_\_\_\_

Insurance information:

Medical: \_\_\_\_\_ Dental: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Insured's name: \_\_\_\_\_ Insured's name: \_\_\_\_\_

ID#: \_\_\_\_\_ ID#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_