George Family Dentistry
Patient Information

Today's Date: ___________________

Patients Name: ____

Date of Birth: ____________________

Street Address: ____

City: ______________________________ State: __________ Zip Code: ______________

Email Address: ____

Sex: _____M _____F Soc. Sec. Number: ________________________

Home Phone Number: _____________________________

Cell Phone Number: ________________________________

Where do you work? ____

Work Number: _________________________

Responsible Party

Who is responsible for the bill? ____

Relationship to patient: ___________________________Date of Birth: _______________

Address (if different):____

Soc. Sec. Number: ___________________________

Best phone number to be reached: ____________________

Insurance Information

(Please give your insurance card to the front desk)

Insurance Information Subscriber's Name: _____________________________________

Date of Birth: ______________________ Relationship to patient: ___________________

Soc. Sec. Number/ID Number: _______________________

What employer is this policy through: ____

What is the name of the insurance company? _________________________________

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In Case of Emergency

Name of local friend or relative (not living at same address):____________________

Relationship to patient: ______________________

Best phone number to be reached: ______________________

I agree that the above information is correct to the best of my knowledge:

Signature: ____ Date: __________
(Patient or Guardian)