LALOR FAMILY DENTAL PATIENT INFORMATION

Patient Full Name: _____ **Date:** _____

PATIENT INFORMATION

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security #: _____

Sex: M F Email: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Our software allows you to use text and/or email for appointment reminders, appointment requests, and to give feedback.

(Check all that apply)

☐ Yes, I would like to receive **TEXT MESSAGES**

☐ Yes, I would like to receive **EMAILS**

☐ No, I am **NOT** interested in receiving texts or emails at this time.

RESPONSIBLE PARTY (Complete if patient is a minor or someone other than the patient is responsible for payment.)

First Name: _____ Last Name: _____ Middle Initial: ____

Responsible Party's Address (if different from patient address above): _____

City: _____ State: _____ Zip: _____

Best Phone Number to Reach Responsible Party: _____

Responsible Party's Birth Date: _____ Responsible Party's Social Security #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: _____ Policy Holder's Social Security #: _____

Policy Holder's Birth Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ Policy Holder's Social Security #: _____

Policy Holder's Birth Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

OTHER

How did you hear about us? _____

If referred, whom may we thank? _____

Please sign and date this form below. Your signature below indicates that the information on this is complete and accurate to the best of your knowledge.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian (if minor) Date