SMOKETOWN FAMILY DENTISTRY

2433 C Old Philadelphia Pike PO Box 369 – Smoketown PA 17576

PATIENT INFORMATION

Last: First: Middle:					Date:	
Email:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Minor / Single / Mar / Div / Sep / Wid		
Birth Date: / /	Age:	Sex: ❑ M ❑ F	Soc. Sec. #:	Home Phone No.:	Cell Phone No.:	
Street Address:		City:		State:	ZIP Code:	
Mailing Address (If different from above)		City:		State:	ZIP Code:	
Patient's/Parent's/Spouse's Occupation:		Employer:		Employer Phone No.:		

Responsible Party:	Social Security No.:	Birth Date: / /	Relationship to Patient:

Authorized members on account:

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES❑ NO❑

EMERGENCY CONTACT

Name: Relationship to patient: Primary phone no.: Secondary Phone no.:

INSURANCE INFORMATION

Subscriber's name:	Birth date: / /	Home Address:	Phone no.:
Soc. Sec. #:	Employer:	Employer address:	Employer phone no.:
Insurance company name:	Insurance phone no.:	Group no.:	Policy ID:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Do you have any additional dental insurance? YES❑ NO❑ If yes please complete the following:

Secondary Insurance Information

Subscriber's name:	Birth date: / /	Home Address:	Phone no.:
Soc. Sec. #	Employer:	Employer address:	Employer phone no.:
Insurance company name:	Insurance phone no.:	Group no.:	Policy ID:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other