Grove City family dentistry

The quality & care you need. **Guaranteed.**

ID: ______ Chart ID ______

First name ______ Last name ______ Middle initial ______ Preferred name ______

Patient is : Policy holder Responsible party

Responsible Party (if someone other than patient)

First name ______ Last name ______ Middle Initial ______

Address ______ Address 2 ______

City, State, Zip ______ Pager ______

Home phone ______ Work phone ______ Ext ______ Cell phone ______

Birth date ______ Social security # ______ Drivers license # ______

◯ Responsible Party is also a Policy holder for patient ◯ Primary insurance policy holder ◯ Secondary insurance policy holder

Patient Information

First name ______ Last name ______ Middle initial ______

Address ______ Address 2 ______

City, State, Zip ______ Pager ______

Home phone ______ Work phone ______ Ext ______ Cell phone ______

Sex: ◯ Male ◯ Female Marital status ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth date ______ Age ______ Social security # ______ Drivers license # ______

Email ______ ◯ I would like to receive correspondences via email

Section 2

Employment Status ◯ Full time ◯ Part time ◯ Retired

Student Status ◯ Full time ◯ Part time

Medicaid ID ______ Preferred Dentist ______

Employer ID ______ Preferred Pharmacy ______

Carrier ID ______ Preferred Hygienist ______

Section 3

Preferred apointment time ______

Who referred you ______

Best number to call ______

Time to call you ______

Emergency name ______

Emergency number ______

Primary Insurance Information

Name of insured ______

Insured social security # ______

Employer ______

Address ______

Address 2 ______

City, State, Zip ______

Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured birth date ______

Insurance company ______

Address ______

Address 2 ______

City, State, Zip ______

Rem. Benefits ______ .00 Rem. Deductible ______ .00

Secondary Insurance Information

Name of insured ______

Insured social security # ______

Employer ______

Address ______

Address 2 ______

City, State, Zip ______

Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured birth date ______

Insurance company ______

Address ______

Address 2 ______

City, State, Zip ______

Rem. Benefits ______ .00 Rem. Deductible ______ .00