

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: Male Family Status: «FamPos»

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____
Street Apartment #
City State Zip Code

In the event of an emergency, whom should we contact? Please list someone NOT living with you.

Name _____ Phone: _____ Relationship to you _____

Responsible Party

Employment Information

Name: _____

The following is for: the patient the person responsible for payment

Employer Name _____ Occupation: _____

Address: _____
Street City, Zip Code Phone

Insurance Information

Name of Insured: _____ Is the insured a patient? Yes No

Insured's Birth Date: _____ ID# or SS#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name and Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

How did you find out about Lighthouse Dental?

Location of our office Yellow Pages Insurance Carrier Friend/Relative Other :

Whom may we thank for referring you to our practice: _____