

PATIENT'S NAME

Last First Initial

IF CHILD; PARENT'S NAME

Last First Middle

SPOUSE

Last First Middle

RESIDENCE-

STREET

CITY STATE ZIP

TELEPHONE:

RES ()

PAGE: () OTHER ()

Date of Birth Male Female Single Married Separated Divorced Widowed Minor (circle)

IF MINOR - PATIENT SOCIAL SECURITY NO.

OTHER FAMILY MEMBERS IN THIS PRACTICE

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU:

Name

Phone ()

Relationship to You

E-MAIL

PATIENT/PARENT

EMPLOYEE NAME

SOCIAL SECURITY #

EMPLOYEE DATE OF BIRTH

EMPLOYER #YRS.

BUSINESS PHONE () CELL ()

DRIVERS LICENSE NO.

DENTAL INSURANCE 1ST COVERAGE (if patient is a minor the parent with the earliest birthday in the calendar year is 1st coverage)

NAME OF INSURANCE CO.

ADDRESS

TELEPHONE ()

POLICY #

UNION LOCAL OR GROUP #

MEDICAL INSURANCE 1ST COVERAGE (medical insurance covers some dental procedures. Please supply information so that we can maximize your coverage)

NAME OF INSURANCE CO.

ADDRESS

POLICY #

GROUP #

SPOUSE

EMPLOYEE NAME

SOCIAL SECURITY #

EMPLOYEE DATE OF BIRTH

EMPLOYER #YRS.

BUSINESS PHONE () CELL ()

DRIVERS LICENSE NO.

DENTAL INSURANCE 2ND COVERAGE (if patient is a minor the parent with the earliest birthday in the calendar year is 1st coverage)

NAME OF INSURANCE CO.

ADDRESS

TELEPHONE ()

POLICY #

UNION LOCAL OR GROUP #

MEDICAL INSURANCE 2ND COVERAGE (medical insurance covers some dental procedures. Please supply information so that we can maximize your coverage)

NAME OF INSURANCE CO.

ADDRESS

POLICY #

GROUP #

N.J. FAMILY CARE/KID CARE PLAN OR STATE ASSISTANCE

MY HMO IS: (By law, if you have any other dental plan, the plan must be submitted before Family Care/Kid Care or State Assistance Plan)

AMERICHoice MERCY UNIVERSITY AMERIGROUP NO HMO

Service Plan None A or B C D (From monthly Eligibility Card)

HMO MEMBER ID #

STATE MEDICAID ID #