NAME:

Last *First* *M.I.* *Preferred*

ADDRESS:

Street or PO Box *City* *State* *Zip Code*

Single
Married
Child

BIRTH DATE *(mm/dd/yyyy) :*

Social Security #

E-mail:

PHONE NUMBERS:

HOME:

CELL:

WORK:

Patient Employer

Employer Phone #

PERSON RESPONSIBLE FOR BILL

RELATIONSHIP TO PATIENT

SSN:

DOB (mm/dd/yyyy):

ADDRESS & PHONE # FOR RESPONSIBLE PARTY (if different from patient)

INSURANCE INFORMATION

PRIMARY *Policy Holder's Full Name*

Relationship to Patient

Policy Holder Social Security #

DOB (mm/dd/yyyy):

Policy Holder Address (if different than patient)

Insurance Company Name

Policy Holder's Employer

Employer Phone #

SECONDARY *Policy Holder's Full Name*

Relationship to Patient

Policy Holder Social Security #

DOB (mm/dd/yyyy):

Policy Holder Address (if different than patient)

Insurance Company Name

Policy Holder's Employer

Employer Phone #

GETTING TO KNOW YOU

1. Is another member of your immediate family (living at the same address) a patient in our practice? If yes, whom?

2. Whom may we thank for referring you?

3. Person to contact for emergency: *Phone Number:*

HIPAA PRIVACY CONTACTS

I am providing written permission for Logan Dental to speak to, or leave messages at, any of the following numbers regarding my dental appointments and/or treatment.:

Name: _____

Phone #: _____

Relation:

Name:

Phone #:

Relation:

_____ _____ _____

Signature of Responsible Party Relationship Date