BAKER SISTERS
FAMILY DENTAL CARE

Patient Information

Date_____

Patient Name _____ Preferred Name_____ Age_____

Gender _____ Birthdate ____/____/____ SINGLE MARRIED DIVORCED WIDOWED

Mailing Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ SS#_____

Email Address _____@ _____How did you hear about our office?_____

Employer Name_____ Work Phone_____

Emergency Contact Name_____ Relationship_____ Phone_____

Responsible Party

Name of person responsible for this account (if **OTHER THAN YOURSELF**) _____

Relationship to patient _____ SS #_____ Birthdate _____/____/____

Home Phone_____ Cell Phone_____ Is this person currently a patient? YES NO

Employer Name_____ Work Phone_____

Primary Dental Insurance Information

Name of Primary Policyholder _____ Relationship to patient _____

SS# or Policyholder ID#_____ Group #_____ Birthdate _____/_____/_____

Employer Name_____

Name of Dental Insurance Company_____ Phone #_____

Secondary Dental Insurance Information

Name of Primary Policyholder _____ Relationship to patient _____

SS# or Policyholder ID#_____ Group #_____ Birthdate _____/_____/_____

Employer Name_____

Name of Dental Insurance Company_____ Phone #_____