WELCOME to Hitchcock Dental

Patient Name: ______________________________

Preferred Name: ____________________________

Male Female

Status: Married Single Child Other

Birthdate:________________________ SS#: ____________________________

Address: ____

City, ST, Zip: ____

email: ____

Ph#: Home: ______________________ Mobile: __________________________

In the event of an emergency, who should we contact?

Name: _____________________ Relationship: ________ Ph#: ________________

Responsible party: Who is responsible for the account?

Name: ____

Relationship to patient: _________________________________

Phone#: ____

Bithdate: ____

SS#: ____

Address: ____

City, ST, Zip: ____

Employer: ____

Occupation: ____

Insurance Information

Primary Insurance:

Name of Insured: ____

Relationship to patient: ___________________________________

Insured's birthdate: _____________________________________

SS#: _____________________

Employer: ____

Insur. Company: ____

Insur. Co. Address: ____

Insur. Co. Ph#: ____

Group#: __________________

Payor ID: _________________

Secondary Insurance:

Name of Insured: ____

Relationship to patient: ___________________________________

Insured's birthdate: _____________________________________

SS#: _____________________

Employer: ____

Insur. Company: ____

Insur. Co. Address: ____

Insur. Co. Ph#: ____

Group#: __________________

Payor ID: _________________