

**PATIENT INSURANCE INFORMATION**

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

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Patient's Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Insurance Plan: \_\_\_\_\_ Group Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Referring Dentist: \_\_\_\_\_

Orthodontist: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Family members who have been patients here: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_