Hutchings Family Dentistry

Patient Information

Patient Name: _____ Date: _____
Last First MI Mr Mrs Ms Dr Preferred Name

Gender (M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Driver's License#: _____ E-mail address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #s: Home _____ Work _____ Ext _____ Best time to call: _____

Cell _____ FAX _____ Other _____

Referral Information

Name of person, office or other source referring you to our practice:

Responsible Party Information

Name: _____ Birth Date: _____
Last First MI Mr Mrs Ms Dr

Relationship to Patient: ☐self ☐spouse ☐parent ☐other Social Security #: _____

Driver's License#: _____ E-mail address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #s: Home _____ Work _____ Cell _____ Best time to call: _____

Employment Information

The following is for : ☐ the patient ☐ the person responsible for the account

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary Insurance Company Name and Address: _____

_____

Name of Insured Person: _____

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company Name and Address: _____

_____

Name of Insured Person: _____

Insured's Birth Date: _____ ID#: _____ Group#: _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other