Grove City family dentistry

The quality & care you need. **Guaranteed.**

ID: _____ Chart ID _____

First name _____ Last name _____ Middle initial ____ Preferred name _____

Patient is : Policy holder Responsible party

Responsible Party (if someone other than patient)

First name _____ Last name _____ Middle Initial ____

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cell phone _____

Birth date _____ Social security # _____ Drivers license # _____

◯ Responsible Party is also a Policy holder for patient ◯ Primary insurance policy holder ◯ Secondary insurance policy holder

Patient Information

First name _____ Last name _____ Middle initial ____

Address _____ Address 2 _____

City, State, Zip _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cell phone _____

Sex: ◯ Male ◯ Female Marital status ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth date _____ Age ____ Social security # _____ Drivers license # _____

Email _____ ◯ I would like to receive correspondences via email

Section 2

Employment Status ◯ Full time ◯ Part time ◯ Retired

Student Status ◯ Full time ◯ Part time

Medicaid ID _____ Preferred Dentist _____

Employer ID _____ Preferred Pharmacy _____

Carrier ID _____ Preferred Hygienist _____

Section 3

Preferred apointment time _____

Who referred you _____

Best number to call _____

Time to call you _____

Emergency name _____

Emergency number _____

Primary Insurance Information

Name of insured _____ Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured social security # _____ Insured birth date _____

Employer _____ Insurance company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits ____ .00 Rem. Deductible ____ .00

Secondary Insurance Information

Name of insured _____ Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured social security # _____ Insured birth date _____

Employer _____ Insurance company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Rem. Benefits ____ .00 Rem. Deductible ____ .00