

Wayne & Julie Scott, D.D.S., P.A.

Patient Information

Patient Name: _____ Date: _____

Driver's License #: _____ E-Mail Address: _____

Male Female Martial Status _____ Social Security #: _____ Birth Date: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

In case of an emergency call _____ Phone _____

Referral Information

Whom may we thank for referring you to our practice? _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

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

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

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

Insurance Plan Name and Phone#: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

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

Insured's Address: _____

Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____

Address: _____

Street _____ City _____ State _____ Zip Code _____

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

Insurance Plan Name and Phone # _____