ESTD. 1986
ANNAPOLIS
FAMILY DENTISTRY

First Name: _____ Last Name: _____ Middle Initial: ____
Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Patient Information:
Address: _____
City: _____ State: _____ Zip Code: _____
Cellphone Number: _____ Home Number: _____
Email: _____
Birthdate: _____ Social Security Number: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired Student Status: ☐ Full Time ☐ Part-Time ☐ N/A
Preferred Pharmacy: _____
Emergency Contact (Name/Number) _____
Referred by: _____ Previous Dentist: _____

Responsible Party (*If other than the patient i.e. Parent/Guardian/Spouse*)

First Name: _____ Last Name: _____ Middle Initial: ____
Birthdate: _____ Social Security Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Cellphone Number: _____ Home Number: _____
Email: _____
☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information:
Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SSN/Dental Insurance ID Number: _____ Insured Birth Date: _____
Employer: _____ Group Name: _____ Group #: _____
Dental Insurance Company: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

Secondary Insurance Information:
Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SSN/Dental Insurance ID Number: _____ Insured Birth Date: _____
Employer: _____ Group Name: _____ Group #: _____
Dental Insurance Company: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____