Patient Insurance and Financial Form

Seattle's Family Dentistry
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Patient Information

Full Name: _____ Date of Birth: _____ Home #: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status (Circle one): **Minor** **Single** **Married** **Divorced** **Separated** **Widowed**

Patient's or Parent's Employer: _____ Occupation: _____ Work #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work#: _____

If patient is a student, name of school or college: _____ City: _____ State: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Please fill out first two column if you have insurance or no insurance. Thank-You!

Responsible Party

Name of person responsible for this account: _____ Relationship to patient _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Driver's License #:_____ State: _____ Birthdate: _____

Employer: _____ Work #: _____

Is this person currently a patient in our office? YES ☐ NO ☐

Primary Dental Insurance

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN #: _____ Years with Employer: _____

Employer: _____ Work #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Union or Local #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Plan Deductible: _____ How much have you used: _____ Maximum Annual Benefit amount: _____

Secondary Dental Insurance

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN #: _____ Years with Employer: _____

Employer: _____ Work #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Union or Local #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Plan Deductible: _____ How much have you used: _____ Maximum Annual Benefit amount: _____

X_____ _____

Signature Date