WELCOME TO HONEA FAMILY DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Social Security# ______________________

______________________ ______ ______________________ ______________________
First Name Initial Last Name Pref. Name

Mailing Address ______________________ Email Address ______________________

City______________ St ______Zip________ Marital Status: ☐ Married ☐ Single ☐ Divorced

Phone #:______________________ Cell Phone#:______________________

Age ______Date of Birth______________ Drivers License#______________________

Employer: ______________________ Work # ______________

Employer Address:______________________

Whom may we thank for referring you: ______________________

Or, how did you find out about our practice:______________________

Notify in case of emergency ______________________ Phone #______________

PRIMARY DENTAL INSURANCE

Person Responsible for Primary Insurance ______________________

Birth Date ____________Social Sec. # ______________________ Home Phone # ______________

Cell Phone # ______________ Work Phone # ______________

Employer: ______________________

Address: ______________________

Insurance Company______________________ Phone #______________

Contract #______________ Group #______________Subscriber# ______________

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

Person Responsible for Secondary Insurance ______________________

Social Sec. # ______________ Date of Birth ______________ Phone #______________

Address if different from patient ______________________

Employer:______________ Address ______________ Phone# ______________

Insurance Co. ______________ Contract#______________ Group # ______________

If unable to keep appointment kindly give 24 hours notice.