LINCOLN WAY FAMILY DENTAL

WELCOME! Thank you for selecting our dental team!
To help us meet your healthcare needs, please fill out this form completely

PATIENT INFORMATION

Name: _____ Date: _____
Birthdate: _____ SSN: _____ Phone Home #: _____
Cell #: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Circle One: Minor Single Married Divorced Widowed
If Student, Name of School/College _____ Circle One: FT PT
Patient/Parent/Guardians' Employer_____ Phone #: _____
Spouse/Domestic Partner_____ Cell #: _____
Emergency Contact_____ Phone #: _____

Whom May We Thank For Referring You? _____

RESPONSIBLE PARTY

Name of Person Responsible for Account: _____ Relationship: _____
Address (if not same as above): _____
Phone Home #:_____ Cell #:_____ Email: _____
Employer: _____ Work #: _____ SSN: _____
Is this person a current patient in our office? Y N

PRIMARY INSURANCE

Name of Insured: _____ Relationship: _____
Birthdate: _____ SSN: _____ Phone #: _____
Employer: _____ Union/Local #: _____
Employer Address: _____ Phone #: _____
Insurance Co. (Dental): _____ Group #: _____ I.D. #: _____
Ins. Co. Address _____ Phone #: _____

If you have additional insurance coverage, please complete the following section:

Secondary Insurance

Name of Insured: _____ Relationship: _____
Birthdate: _____ SSN: _____ Phone #: _____
Employer: _____ Union/Local #: _____
Employer Address: _____ Phone #: _____
Insurance Co. (Dental): _____ Group #: _____ I.D. #: _____
Ins. Co. Address _____ Phone #: _____