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