MEDICAL ALERT

ACCOUNT NUMBER_____

PATIENT INFORMATION

(PLEASE PRINT)

(Dr/Mr/Mrs/Ms/Miss) First Middle Last Jr/Sr

Street City State Zip

( ) ( ) Email Address:

Home Phone Work Phone May we contact you by Email? Y N

Patient Social Security Number Patient Date of Birth M or F Sex

Emergency Contact **Phone**

How did you hear about us?

(please be as specific as possible)

Whom may we thank for referring you?

(Please list the name of the person, doctor or organization and address if possible)

INSURANCE INFORMATION

Do you have **Dental** Insurance? ( ) Yes ( ) No

Do you have **Secondary Dental** Insurance? ( ) Yes ( ) No

PRIMARY INSURED

Subscriber Name:

Subscriber SSN:

Date of Birth:

Relationship to Subscriber: ( )Self ( )Spouse ( )Child ( )Other

Employer Name:

Employer Phone #:

Insurance Company:

Insurance Group #:

SECONDARY INSURED

Subscriber Name:

Subscriber SSN:

Date of Birth:

Relationship to Subscriber: ( )Self ( )Spouse ( )Child ( )Other

Employer Name:

Employer Phone #:

Insurance Company:

Insurance Group #:

Please present card to receptionist to be photocopied

HIPAA Privacy Practices Notice effective April 14, 2003 provided.

Initials/Date_____