Patient Information

MICHAEL D. FARMER, D.M.D.
general dentistry

FULL NAME_____ **PEFERRED NAME**_____ **M F**

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **WORK**_____ **EXT**_____ **CELL**_____

SS #_____ **DATE OF BIRTH**_____ **CIRCLE ONE:** MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

EMPLOYED BY_____ **OCCUPATION**_____

IF COLLEGE STUDENT, NAME OF SCHOOL_____ **CITY**_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE #**_____

Spouse Information

SPOUSE FULL NAME_____ **BIRTHDATE**_____ **SOCIAL SECURITY #**_____

SPOUSE EMPLOYER_____ **OCCUPATION**_____ **WORK PHONE**_____

Responsible Party

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ **RELATIONSHIP TO PATIENT**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **WORK**_____ **EXT**_____ **CELL**_____

Dental Insurance

NAME OF INSURED_____ **RELATIONSHIP TO PATIENT**_____

SOCIAL SECURITY#_____ **DATE OF BIRTH**_____ **DATE EMPLOYED**_____

EMPLOYED BY_____ **OCCUPATION**_____

EMPLOYER ADDRESS_____ **CITY**_____ **STATE**_____

INSURANCE COMPANY_____ **GROUP #**_____ **POLICY #**_____

INSURANCE ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

Additional Dental Insurance

NAME OF INSURED_____ **RELATIONSHIP TO PATIENT**_____

SOCIAL SECURITY#_____ **DATE OF BIRTH**_____ **DATE EMPLOYED**_____

EMPLOYED BY_____ **OCCUPATION**_____

EMPLOYER ADDRESS_____ **CITY**_____ **STATE**_____

INSURANCE COMPANY_____ **GROUP #**_____ **POLICY #**_____

INSURANCE ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) ***DATE***