PATIENT INFORMATION

JAX BEACHES FAMILY DENTISTRY

Patient Name _____ Date of Birth _____ Age _____ Today's Date _____

❍ Miss ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. I prefer to be called _____ ❍ Male ❍ Female

Home Address _____ City _____ State _____ Zip ____

❍ Single ❍ Married ❍Divorced ❍ Widowed ❍ Separated SS# _____ -____ -____ DL# _____

Home Phone _____ Cell _____ Work _____ Ext ____ Email _____

Employer _____ Address _____ Occupation _____ How long? _____

Where and when can we reach you? _____

Other family members seen by us? _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Dental Insurance _____ Insurance Company Name _____ Group/Plan/Local/Policy# _____

Address _____ Phone _____

Insured's Name _____ **Relation** _____

Insured's date of birth? _____**Insured's SS#** _____ -___ -_____ **Insured's Employer** _____

In the event of an emergency, is there someone that lives near you that we should contact?

Name _____ Relation _____ Home Phone _____ Work / Cell _____

How did you hear about Jax Beaches Family Dentistry?

❍Yellow Pages ❍Mail / Coupon ❍Referral ❍Internet ❍TV ❍Billboard ❍Drive-By

❍Other _____

Whom may we thank for referring you? _____