

**Bethlehem Town Family Dental**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list other family members we have seen: \_\_\_\_\_

**INSURANCE INFORMATION**

Dental Insurance Company Name \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_ Insurance Patient ID # \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured SS# \_\_\_\_\_ Insured Birthdate \_\_\_\_\_ Group# \_\_\_\_\_

Insured Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**OTHER INFORMATION**

In case of emergency, who would you like us to contact? \_\_\_\_\_

Contact's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Your Physician \_\_\_\_\_ Name of Your Former Dentist \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_

X \_\_\_\_\_ X \_\_\_\_\_

Patient Signature

Date