

THE FAMILY DENTAL CENTER
2781 Oakdale Blvd., Ste. 3 Coralville, IA 52241
319-351-3414

PATIENT INFORMATION (CONFIDENTIAL)

DATE: _____ SSN/ID#: _____

PATIENT'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CHECK ONE: MINOR SINGLE MARRIED

HOME PHONE: _____ WORK PH: _____ CELL: _____

EMPLOYER: _____ CITY, STATE: _____

PERSON RESPONSIBLE FOR ACCOUNT: (PATIENT'S UNDER 18 YEARS OLD ONLY)

NAME: _____ ADDRESS: _____

STATE: _____ ZIP: _____

HOME PH: _____ WORK PH: _____ CELL: _____

DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER: _____ BIRTHDATE: _____

ADDRESS: _____ INSURANCE ID: _____

RELATIONSHIP TO PATIENT: _____ HOME PH: _____

EMPLOYER: _____ WORK PH: _____

INSURANCE CO: _____ GROUP#: _____

CLAIMS ADDRESS: _____ UNION/LOCAL: _____

CITY, STATE ,ZIP: _____ PHONE: _____

*DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO

Signature _____ Print Name _____