



FOX RIVER PERIODONTICS, P.C.

WELCOME TO FOX RIVER PERIODONTICS, P.C.

1 Patient Information

Date

Patient _____

_____ Last Name _____ First Name _____ Initial _____ Preferred Name _____

Birthdate _____ Age _____ Social Security # or Dental Insurance ID# _____

Male Female Minor Single Married Widowed

Home Address _____

City, State, Zip _____

Employer _____ Occupation _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext # _____

Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home # _____ Work # _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Social Security # or Dental Insurance ID# _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext # _____

Employer _____

Employer's Address _____

City, State, Zip _____

3 Dental Insurance Information

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Social Security # or insurance ID# _____

Employer _____

Insurance Company _____

Group # _____

Employee ID/Cert. # _____

Insurance Co. Address _____

Insurance Phone # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Social Security # or insurance ID# _____

Employer _____

Insurance Company _____

Group # _____

Employee ID/Cert. # _____

Insurance Co. Address _____

Insurance Phone # _____

4 Referral Information

Whom may we thank for referring you to our practice ? _____

OVER

