Sea Dental Care

WELCOME

Thank you for selecting our Sea Dental Care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION

Name____Birthdate___________Age_______________

Address________________________________City______________State________Zip_____________

Email_______________________________SS#/SIN____

Best Phone #(____) _____-________ h w c Alternate # (____) _____-________ h w c

Circle One: Minor Single Married Separated Divorced Widowed

Employer/School (if student) ____________________________Phone# (____) _____- ___________

Address__________________________City_______________State________Zip________________

Spouse or Parent/Guardian _____________________________Phone# (____) ______-___________

In case of emergency, contact: ____

Whom may we thank for referring you? ____

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____

Relationship to Patient ____

Address__________________________City_______________State__________Zip________________

Best Phone # (____) _____-______ BirthDate___________________ SS#/SIN __________________

PRIMARY INSURANCE

Policy Holder________________________SS#/SIN_______________________Birthdate__________

Relationship to Patient (circle one): Self Spouse Parent Other

Employer__________________________________Group#__________________________________

Insurance Carrier__________________________________Phone:____________________________

SECONDARY INSURANCE

Policy Holder________________________SS#/SIN_______________________Birthdate__________

Relationship to Patient (circle one): Self Spouse Parent Other

Employer__________________________________Group#__________________________________

Insurance Carrier__________________________________Phone:____________________________