Groy Family Dentistry

We would like to welcome you to our dental practice and thank you for choosing us as your dental healthcare team.
Please fill out this form as completely as you can. If you have any questions we'll be glad to help you.
All information is confidential.

Personal History

Patient Name_____ Soc. Sec. # _____Today's Date_____
Address_____
City _____ State_____ Zip _____ Home Phone_____
Cell Phone_____ E-mail _____
Male _____ Female _____ Birth Date _____
Check One: Minor _____ Single _____ Married _____ Divorced _____ Widowed _____

Your Employer_____
Business Address_____
City _____ State _____ Zip _____
Work Phone _____ Business e-mail_____

Spouse Employer _____
Business Address _____
City _____ State _____ Zip _____
Work Phone _____ Business e-mail_____

Person Financially Responsible_____ Relationship to Patient_____

If Patient is a Child:
Mother's name _____Father's Name_____
Whose address is different from above? N/A _____ Mother _____ Father _____
Address _____
City _____State _____ Zip _____

In the event of an emergency, who should we contact _____
Relationship: _____Telephone: _____

Who may we thank for referring you? _____

Dental Insurance Information

Do <u>you</u> have dental insurance? **Yes** **No** Does <u>your spouse</u> have dental insurance? **Yes** **No**

Whose insurance is primary for your children? _____

Primary Dental Ins. Company _____Primary SS# _____
Primary Birth Date _____ Relationship to Patient_____
Primary Employer _____Group Plan #_____ ID# _____
Address: _____City_____ State_____ Zip _____

Secondary Dental Ins. Company _____Secondary SS# _____
Secondary Birth Date _____ Relationship to Patient_____
Secondary Employer _____ Group Plan # _____ ID# _____
Address: _____ City_____ State_____ Zip _____