email: ______________________

Associated Family Dentisits
NEW ACCOUNT APPLICATION

Financially Responsible Party/Patient

Last Name:______________________ First:____________________ M.I.____ Nickname:__________________

Male/Female Single/Married/ Divorced/ Widowed Birthdate:___/___/___ Relationship to patient:____________

SS#:____________________________________ DL#:____

Address:____
City State Zip

Home Phone:____________________________ Work Phone:____________________________________

Employer: ____ Phone:________________

Employer Address:____

How long employed?______ Occupation:____________________ Employer contact allowed: Y/N

Minor Patient/Spouse Information

Last Name:____________________ First:____________________ M.I.____ Nickname:________________

Male / Female Birthdate:___/___/___ SS#_______________________ DL#____________________

Address:____ College Student: Y / N Full time / Part time

Home Phone:______________ Work Phone:____________________ Employer:____________________

Employers Address:____ Phone:________________

How long employed: __________ Occupation:____________________ Employer contact allowed: Y / N

Emergency Contacts

Last Name:____________________ First:____________________ Phone #:____________________
Relationship to patient:____

Last Name:____________________ First:____________________ Phone #:____________________
Relationship to patient:____

Primary Insurance Information

Subscriber's name_______________________________ SS#____________________Birthdate___/___/___

Insurance Co.:____________________ Employer:____________________ Relationship to patient______________

Secondary Insurance Information

Subscriber's name_______________________________ SS#____________________Birthdate___/___/___

Insurance Co.:____________________ Employer:____________________ Relationship to patient______________