

**Associated Family Dentists  
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: \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Rent /Own /Other \_\_\_\_\_  
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 \_\_\_\_\_

