Michael Warner Family Dental

**Date:**_____

**Patient Name** _____ **Birth Date**_____
Last, First MI (preferred name)

**Marital Status**:☐ Married ☐Single ☐ Divorced ☐Separated ☐Widowed ☐ Sex ☐ Male ☐Female

**Address**:_____
Street City State Zip

**Home Phone**: _____ **Cell**: _____ **Work**: _____

**Social Security #:** _____ **Driver's license**:_____ **E-mail**_____

**Employer:** _____ **Occupation**:_____
**Responsible Party is also Policy Holder for Patient: Yes**_____ **No**_____
**Responsible Party of Patient if Insurance is not applicable**_____
**Referral By:**_____ **Internet**_____ **Insurance List**_____ **Drive By**____

**INSURANCE INFORMATION**
**Primary**
Name of Insured:_____ Is Insured a patient? ____Yes ____No
Last, First MI
**Insured's Birth Date:**_____ **Insurance ID #**_____ **Social** Security **#**_____
**Insurance Company** _____
**Address of Insurance**_____ **Phone#**_____
**Insured Employer Name:**_____ **Work #**_____

**INSURANCE INFORMATION**
**Secondary**
Name of Insured:_____ Is Insured a patient? ____Yes ____No
Last, First MI
**Insured's Birth Date:**_____ **Insurance ID #**_____ **Social** Security **#**_____
**Insurance Company** _____
**Address of Insurance**_____ **Phone#**_____
**Insured Employer Name:**_____ **Work #**_____

**I acknowledge that I have read and reviewed a copy of Warner Family Dental Notice of Privacy Practices.**
Patient name _____
Signature _____ Date _____