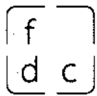


**Family Dental Care**
of Indiana, LLC

# Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. **Please Print.** All information will be kept confidential.

Today's Date: ____________________

First Name________________________________ M.I._____ Last Name________________________________
Male Female Birthdate__________ Age____ SSN:________________Email____________________________
Address_______________________________________________City_________________State____Zip________
Phone __________________ Other Phone ______________________ Have you been seen in our practice Y N
Referred By_______________________________________________Has a family member been seen here Y N
Previous Dentist _____________________ Orthodontist __________________ Medical Dr.______________
Driver's Lic. #__________________ Nearest relative not living with you_________________Tel.__________
Employer __________________________________Work phone________________
If patient is a student, name of school/college____________________________________________________
Person to contact in case of emergency_____________________________________Phone ________________

**Responsible Party**

☐Self (skip this section) ☐Spouse ☐Father ☐Mother ☐Other ____________________________
Name _________________________________ SSN_________________ Birthdate ________________Age_____
Phone __________________________Cell Phone_____________________ Email___________________________
Address___________________________________________City_______________State_____ Zip__________
Driver Lic #___________________ Employer __________________________ Work Phone #_______________
Is this person currently a patient at our office? Yes No

**Spouse or other Guarantor Information** (If different from above)

First______________ Last____________________________ Relation _________ SSN__________ DOB________
Address_____________________________________________City_________________State_____ Zip________
Phone__________________ Employer ___________________________ Work Phone ____________________

**Insurance Information**

Student : ☐ full time ☐part time ☐not School Name and Address

__________________________________

Marital Status: ☐married ☐divorced ☐widow ☐single ☐legally separated
Employed: ☐full time ☐part time ☐retired ☐not employed

**Primary Insurance**

Employer __________________________ Phone______________ Plan _______________
Address ___________________________City_______________State _____ Zip_____________
Insurance company ________________________________ ID # ___________________ Phone _____________
Ins. Co. Address __________________________ City __________________ State ______ Zip ____________
Group #____________________ Insured Name ____________________________________________________
Relation ________________Birthdate____________ M F SSN_______________Phone__________________
Address_________________________________________ City _____________State____ Zip_______________

**Secondary Insurance**

Employer __________________________ Phone______________ Plan _______________
Address ___________________________City_______________State _____ Zip_____________
Insurance company ________________________________ ID # ___________________ Phone _____________
Ins. Co. Address __________________________ City __________________ State ______ Zip ____________
Group #____________________ Insured Name ____________________________________________________
Relation ________________Birthdate____________ M F SSN_______________Phone__________________
Address_________________________________________ City _____________State____ Zip_______________

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

**Signature (Patient or guardian):** ______________________________________ **Date:**______________