KENOSHA BREEZE FAMILY DENTAL

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Preferred Name:_____

Patient is: □ **Responsible Party** □ **Policy Holder**

Patient Information:

Address: _____ **Address 2:**_____

City:_____ **State:**_____ **Zip:**_____

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

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

Birth date:_____ **Social Security #:**_____

Email:_____ □ **I would like to receive email correspondences**

Employment Status: ○ **Full Time** ○ **Part Time** ○ **Self Employed** ○ **Retired** ○ **Unemployed**

Student Status: ○**Full Time** ○ **Part Time**

Preferred Pharmacy:_____ **Phone #:**_____

Who can we thank for referring you?_____

Primary Insurance Information:

Name of Insured:_____ **Relationship to Insured:** ○**Self** ○**Spouse** ○**Child**

Provider ID:_____ **Insured Social Security #:**_____

Insured Birth date:_____ **Employer:**_____ **Insurance Company:**_____

Secondary Insurance Information:

Name of Insured:_____ **Relationship to Insured:** ○**Self** ○**Spouse** ○**Child**

Provider ID:_____ **Insured Social Security #:**_____

Insured Birth date:_____ **Employer:**_____ **Insurance Company:**_____

IN CASE OF EMERGENCY

Name of friend or relative:_____ **Relationship to Patient:**_____

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

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient/Guardian Signature_____ **Date**_____