FederalWay DENTISTRY

Personal Information

Please Circle One: Mr. Mrs. Ms. Dr. **E-mail Address:** _____

Name: First _____ Middle _____ Last _____

Responsible Party: ___Self ___Other _____ **Please Circle One:** Single Married

Birth Date: _____ / _____ / _____ **Social Security Number:** _____-_____-_____

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

Phone Number: Home ( ) _____-_____ Cell ( ) _____- _____

Employer: _____Phone : _____Occupation:_____

In case of emergency, please notify: _____ Phone: _____

Primary Dental Insurance

Subscriber's Name: _____

Social Security or ID #: _____ Subscriber's Birth Date _____ / _____ / _____

Employer: _____Phone_____ Group/Local #: _____

Name & Address of Ins. Co: _____

Phone Number of Insurance Company: ( ) _____ - _____

Additional Dental Insurance : Subscriber's Name: _____

Social Security or ID #: _____ Subscriber's Birth Date _____ / _____ / _____

Employer: _____ Group/Local #: _____

Name & Address of INS Co: _____

Phone Number of Insurance Company: ( ) _____ - _____

It is my responsibility to understand how my Insurance plan works. I also understand that if the Insurance does not pay as estimated, I will be responsible for any additional out of pocket co-pays that may be due. I authorize Federal Way Dentistry to bill my Insurance.

X_____Date_____