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HARMONY FAMILY DENTISTRY

phone (360) 882 - 7866
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Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME_____ PREFERRED NAME _____

☐ Male ☐ Female Social Security No._____-_____-_____ Birthdate_____/_____/

Mailing Address_____ Email_____

City_____ State_____ Zip Code_____ Home Phone No.(___) _____

Cell Phone No.(_)_____ How should we contact you? Home ☐ Work ☐ Cell ☐ Email ☐

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Patient Occupation_____ Employer_____ Work Phone (_____) _____

Name of Spouse_____ Birthdate_____/_____/_____ SSN _____

Spouse Occupation_____ Employer_____ Work Phone (_____) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name_____ Home Ph. No.(_____)_____ Work Ph. No.(_) _____

Relationship to patient _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

☐Cash ☐Check ☐Bankcard ☐Insurance

Person responsible for payment: _____

Primary Dental Insurance

Employee_____

Relationship to Patient _____

Employer_____

Insurance Co._____ Group#_____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

Secondary Dental Insurance

Employee_____

Relationship to Patient _____

Employer_____

Insurance Co._____ Group#_____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

I have been given and understand the Harmony Family Dentistry HIPPA Notices of Privacy Act.

Signature_____ Date _____

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