Kearny Dental Associates

Date_____

Patient Information (CONFIDENTIAL)

Name_____ Birthdate_____ SS#/SIN_____
Address_____ City_____ State_____ Zip._____
Email Address_____
Home Phone_____ Cell Phone_____ Work Phone_____

Check Appropriate Box: ☐ Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College_____ City_____ State_____ ☐Full time ☐Part time
Patient or Parent/Guardian's Employer_____ Work Phone:_____
Business Address_____ City_____ State_____ Zip._____
Spouse or Parent/ Guardian's Name_____ Employer_____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency? _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to patient_____
Address_____ Home Phone_____
Email _____ Cell Phone_____
Driver's License #_____Birthdate_____ Financial Institution_____
Employer_____ Work Phone_____ SS#/SIN_____

Is this Person Currently a Patient in our Office? ☐Yes ☐No
For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐Cash ☐Personal Check Credit Card: ☐VISA ☐Master Card ☐I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#/SIN_____ Date Employed_____
Name of Employer_____ Union or Local#_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip._____
Insurance Company_____ Group#_____ Policy/ID #_____
Ins. Co. Address_____ City_____ Sate_____ Zip._____
How Much is your Deductible? _____ How Much Have You Used? _____Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCES? ☐*YES* ☐NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____
Birthdate_____ SS#/SIN_____ Date Employed_____
Name of Employer_____ Union or Local#_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip._____
Insurance Company_____ Group#_____ Policy/ ID#_____
Ins. Co. Address_____ City_____ State_____ Zip._____
How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit _____