Capital City Dental-Dr. Benjamin Horgan

Patient Information

Patient’s Name: Date:

 Last First MI Preferred Name

Gender (M/F) Marital Status: Birth Date: Social Security #:

E-Mail Address:

Address:

 Street Apt. #

 City State Zip Code

Phone #s: Home: Work: Ext: Best time to call:

 FAX: Pager: Other/Cell:

**Referred By:**

In Case of Emergency, Contact

Name: Relationship:

Home Phone: ( ) Cell Phone: Work Phone: ( )

Employment Information

The following is for :\_\_\_\_\_ the patient \_\_\_\_\_ the person Responsible for payment

Employer Name:

Address:

Street City State Zip Code Phone

Spouse or Responsible Party Information

Name: Date:

 Last First MI Preferred Name

Gender (M/F) Marital Status: Birth Date: Social Security #:

E-Mail Address:

Address:

 Street Apt. #

 City State Zip Code

Phone #s: Home: Work: Ext: Best time to call:

 FAX: Pager: Other/Cell:

The following is for :\_\_\_\_\_ the patient \_\_\_\_\_ the person Responsible for payment

Employer Name:

Address:

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: Date of Birth:

Group # ID# Social Security#

Insurance Company:

Insurance Group/Employer Name:

Patient’s relationship to insured: self spouse child other

Secondary

Name of Insured: Date of Birth:

Group # ID# Social Security#

Insurance Company:

Insurance Group/Employer Name:

Patient’s relationship to insured: self spouse child other rev 10/8/13