TRUMMER FAMILY DENTISTRY

1180 High St., Hanover, PA 17331 717-632-6565

We need to have the following information in order to upgrade and maintain accurate records. This is especially important in enabling us to have the computer ability to complete your insurance forms in order for you to receive the benefits to which you are entitled. Your medical history must also be current in order that we can be made aware of any conditions affecting treatment. This information will remain strictly confidential.

PATIENT INFORMATION

Name _____ (LAST / FIRST / MIDDLE) Prefer to be called: _____

Sex _____ Birthdate _____ Social Security No. _____ Home Phone _____

Address _____ (CITY / STATE / ZIP) Cell Phone _____

E-mail address _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Parent's or Patient's Employer _____ Work Phone _____

Business Address _____ (CITY / STATE / ZIP)

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If patient is a Student, name of School/College _____

Address _____

Person to call in case of any emergency _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to Patient _____

Address _____ (CITY / STATE / ZIP)

Home Phone _____ Employer _____ Work/Cell Phone _____

E-mail Address _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security No. _____

Name of Employer _____ Work Phone _____

Address of Employer _____ (CITY / STATE / ZIP)

Insurance Company _____ Group No. _____ Ins. Co. Phone # _____

Insurance Company Address _____ (CITY / STATE / ZIP)

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security No. _____

Name of Employer _____ Work Phone _____

Address of Employer _____ (CITY / STATE / ZIP)

Insurance Company _____ Group No. _____ Ins. Co. Phone # _____

Insurance Company Address _____ (CITY / STATE / ZIP)

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____