Great Lakes Dental Care P.C.

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LASER DENTAL CENTER

Patient Information (Confidential): Today's Date: _____

Patient's Full Name (Last, First, Middle): _____ Birth Date: _____

Gender: Male ☐ Female ☐ Status: Married ☐ Single ☐ Other ☐ Email Address: _____

Social Security #: _____ Driver's License #: _____ State: _____

Address: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Name of Employer: _____ If Student: Full Time ☐ Part Time ☐

Name of School: _____ City in Which School is Located: _____

Responsible Party Information:

Self: ☐ If Other, Full Name (Last, First, Middle): _____ Relationship to Patient: _____

If "Other" please complete: Birth Date: _____ Social Security #: _____

Driver's License #: _____ State: _____ (need copy)

Address: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Employer: _____ Phone: _____

Address: _____ Zip Code: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____ Zip Code: _____

Insurance Information:

Primary Insurance Company: _____ Insurance Address: _____

Group #: _____ Subscriber ID (if available): _____

Name of Insured: _____ Address: _____

Insured's Birth Date: _____ Social Security #: _____ Phone number: _____

Name of Employer: _____

Do you have any additional insurance? No ☐ Yes ☐ If yes, please complete the following:

Secondary Insurance Company: _____ Insurance Address: _____

Group #: _____ Subscriber ID (if available): _____

Name of Insured: _____ Address: _____

Insured's Birth Date: _____ Social Security #: _____ Phone number: _____

Name of Employer: _____ **Signature:** _____