CAMANO ISLAND DENTAL CENTER

810 Rekdal Rd
Camano Island Wa 98282
(360) 629-4097
www.camanodental.com

Today's Date:______________ **Preferred Phone Number:** ________________

PATIENT INFORMATION

PATIENT: ____
LAST NAME FIRST NAME MIDDLE NAME
NAME PREFERRED: ____________________________________
ADDRESS: ____
CITY: ______________________ STATE: __________ ZIP:____________
HOME PHONE: ________________ CELL PHONE: __________________ WORK PHONE:________________
BIRTHDATE:____________ GENDER: MALE ☐ FEMALE ☐
MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐
IF PATIENT IS A CHILD, PARENT NAME: ____________________________
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? ____________________
NAME PHONE NUMBER
PERSON RESPONSIBLE FOR THIS ACCOUNT:______________________________
LAST NAME FIRST NAME MIDDLE INITIAL
ADDRESS IF DIFFERENT FROM PATIENT: ____________________________
HOME PHONE NUMBER:____________________________ EMPLOYER:______________________
OCCUPATION:____________________ BUSINESS PHONE:______________________________
BUSINESS ADDRESS: ____

PRIMARY INSURANCE

POLICY HOLDER'S NAME: ______________________________________
LAST NAME FIRST NAME MIDDLE INITIAL
BIRTHDATE: ______________SOC. SEC. # __________________ RELATION TO PATIENT:______________
POLICY HOLDER'S EMPLOYER:______________________ BUSINESS PHONE:______________________
INSURANCE COMPANY:____________________________ GROUP NUMBER: __________________________
EFFECTIVE DATE: __________________

SECONDARY INSURANCE

POLICY HOLDER'S NAME: ______________________________________
LAST NAME FIRST NAME MIDDLE INITIAL
BIRTHDATE:______________SOC. SEC. # ___________________ RELATION TO PATIENT: ______________
POLICY HOLDER'S EMPLOYER: _____________________ BUSINESS PHONE:______________________
INSURANCE COMPANY: ____________________________ GROUP NUMBER: __________________________
EFFECTIVE DATE: ___________________