Richardson DMD, Inc.

Demographic and Insurance Information **Today's Date _____**

PATIENT INFORMATION

Patient Name: _____ _____
Last, First, MI *Preferred Name*

Date of Birth: _____ **Gender:** _____ **Marital Status:** _____

Additional Dependents:

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Whom may we thank for referring you: _____

ADDRESS AND CONTACT INFORMATION

Mailing Address: _____ **Cell Phone:** _____

_____ **Home Phone:** _____

Email Address: _____

May we email or text you a reminder? Yes / No (Circle One)

Emergency Contact: _____ **Phone:** _____

Would you like the emergency contact authorized as a personal representative on the billing account? Y / N
Please Initial _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **Member ID:**_____**Group #:** _____

Subscriber Name and Date of Birth (If other than the patient): _____

Sub SSN: _____ **Sub Employer:** _____**Relationship to Sub:**_____

Secondary Insurance Name: _____**Member ID:**_____ **Group #:** _____

Subscriber Name and Date of Birth (If other than the patient): _____

Sub SSN: _____ **Sub Employer:** _____**Relationship to Sub:**_____