William J. Bennett III, D.D.S & Associates

PATIENT INFORMATION

Date: _____

Last Name: _____

First Name: _____ MI: _____

I prefer to be called: _____

Patient is: ☐ Policy Holder ☐ Responsible Party

Birthdate: _____ Age: _____ SS# _____

Drivers License: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____

Work #: _____ Ext.: _____

Sex: ☐Male ☐Female

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

E-mail: _____

☐ I would like to receive correspondences via e-mail.

Employment Status: ☐Part Time ☐Full Time ☐Retired

Student Status: ☐Part Time ☐Full Time

Preferred Pharmacy: _____

Who may we thank for referring you?

Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY

☐ Check here if same as above.

Name: _____

Birthdate: _____ Age: _____ SS#: _____

Drivers License: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____

Work #: _____ Ext.: _____

☐Responsible Party is also a Policy Holder for Patient

☐Primary Insurance Policy Holder

☐Secondary Insurance Policy Holder

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Group #: _____

ABOUT YOUR SMILE

Are you happy with your smile?	☐ Yes	☐ No
Are you interested in teeth whitening?	☐ Yes	☐ No
Would you like information on Invisalign?	☐ Yes	☐ No