Welcome

GLASTONBURY FAMILY DENTAL

Thank You for Selecting Our Practice.

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help. All information given is entirely confidential.

Patient Information

Date _____

Name _____ Preferred Name (if any) _____

Social Security Number _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School or College _____

City _____ State _____ ☐ Part Time Student ☐ Full Time Student

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Where Would You Like to be Reached? _____

Person to Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient's or Parent's Employer _____ Occupation _____

Employer Address _____ Work Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ AMEX ☐ VISA ☐ MasterCard ☐ I wish to discuss payment options

Insurance Information (if applicable)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Employer _____ Union or Local Number _____ Work Phone _____

Insurance Company _____ Group / Policy Number _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Please Complete the Following.

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Employer _____ Union or Local Number _____ Work Phone _____

Insurance Company _____ Group / Policy Number _____

Over Please