JUST FOR GRINS
family dentistry

Patient Information

Patient's Name:_____
Last First Middle Preference

Date of Birth:_____ Male / Female Marital Status:_____ Social Security #:_____

Driver's License#:_____ State:_____ Employer: _____

Address: _____
Street Apt. # City State Zip

Cell: _____ Home: _____ Work: _____ ext_____

Email: _____ How did you hear about us? : _____

Spouse's Name:_____ Date of Birth:_____ Social Security #:_____

Spouse's employer: _____ Spouse's phone number: _____

Is a member of your family a patient here: Yes/No Name:_____

Emergency Contact:_____ Phone: _____ Relation: _____

Insurance Information

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Employer: _____

Insurance Co: _____ Group #: _____ Phone: _____

I hereby authorize Just For Grins to affix my name to insurance claims and payments. I authorize payment of dental benefits, otherwise payable to me, directly to Just For Grins.

Patient's Signature:_____ Date:_____

Parent/Guardian signature if patient is a minor:_____