JUST FOR GRINS
family dentistry

Patient's Name:_____
Last First Middle Preference

Birth date:_____ Male / Female:_____ Social Security# _____

Address: _____
Street Apt. # City State Zip

Best Contact Number: _____ Family Email Address: _____

Patient lives with: _____ How did you hear about us? : _____

Is a member of your family a patient here:_____ Name:_____

Primary Guardian/Parent

Name: _____ Date of Birth: _____ Driver's License# :_____

Relationship to Patient: _____ Phone#: _____

Address _____

Employer: _____ Social Security # _____

Secondary Guardian/Parent

Name: _____ Date of Birth: _____ Driver's License# :_____

Relationship to Patient: _____ Phone#: _____

Address _____

Employer: _____ Social Security # _____

Emergency Contact Information: (Not living with patient)

Name: _____ Relationship to child: _____

Phone#: _____ Address _____

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/Guardian Signature:_____ Date:_____