Midtown Dentistry

Patient Information

Patient Name_____

Address_____City_____State_____Zip_____

Birthday_____Social Sec#_____Sex_____Marital Status_____

Home ph_____Cell ph_____Work ph_____

Employer_____Employment status _____

Student status Full time _____ Part time _____ Name of College _____

Email _____

Spouse Name _____Spouse employer_____

Emergency contact_____Relationship_____phone#_____

Pharmacy used _____phone#_____

Preferred confirmation method: ____Text Message ____E-mail _____Both _____Phone call

Billing Name and Address if different from patient:

Name_____

Address_____City_____State_____Zip_____

Referred By: _____

Primary Insurance Information (please provide copy of card)

Name of Insurance_____Customer service phone_____

Name of Insured_____Relationship to patient_____

Employer_____Employer address_____

Social Sec# or ID#_____Date of Birth_____Group#_____

Secondary Insurance Information (please provide copy of card)

Name of Insurance_____Customer service phone_____

Name of Insured_____Relationship to patient_____

Employer_____Employer address_____

Social Sec# or ID#_____Date of Birth_____Group#_____

Authorization to release information to insurance companies.
Authorization for insurance to pay **Midtown Dentistry Dr. Daniel Griffiths**

_____ _____

Signature Date