Joseph E. Sheehan D.D.S., P.C.
General Family Dentistry

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PATIENT CONTACT & INSURANCE INFORMATION (Confidential)

PATIENT CONTACT INFORMATION

Name:________________________________ Birth Date:_____________Email:___________________________

Address:____ City:______________ State:_______ Zip:_________

Home Phone:_________________ Cell Phone:_________________ Social Security #:_______-_______-________

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's or Parent's Employer:__________________________________ Work Phone:______________________

Employer's Address:________________________________ City:______________ State:_______ Zip:_________

Spouse's or Parent's Name:____

Spouse's or Parent's Employer:__________________________________ Work Phone:______________________

Emergency Contact:____ Phone:___________________________

Who may we thank for referring you?____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured:____ Relationship to Patient:______________

Birth Date:_________________ Social Security #:________________ Driver's License #:____________________

Employer's Name:____ Work Phone:______________________

Employer's Address:________________________________ City:______________ State:_______ Zip:_________

Insurance Company:___________________________ Group #:_______________ Plan #:_____________________

Insurance Co. Address:_____________________________ City:______________ State:_______ Zip:_________

Deductible: $________________________________ Maximum Annual Benefit: $__________________________

If you have any additional insurance, please complete this section:

SECONDARY INSURANCE

Name of Insured:____ Relationship to Patient:______________

Birth Date:_________________ Social Security #:________________ Driver's License #:____________________

Employer's Name:____ Work Phone:______________________

Employer's Address:________________________________ City:______________ State:_______ Zip:_________

Insurance Company:___________________________ Group #:_______________ Plan #:_____________________

Insurance Co. Address:_____________________________ City:______________ State:_______ Zip:_________

Deductible: $________________________________ Maximum Annual Benefit: $__________________________

FOR OFFICE USE

Dental Insurance____

Group #:________________ Coverage A_______________________ Effective Date_____________________

Plan #:_________________ Coverage B_______________________ Coverage Dates____________________

Max:___________________ Deductible_________________________

Revision: July 20, 2011