SANDY FAMILY
DENTISTRY
DR. RUSSELL G. LEWIS

Sandy Family Dentistry
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PATIENT INFORMATION SHEET

Date:_____ Referred By:_____

Patient's Name: _____ SSN:_____ Birthdate: _____ Age:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone:_____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D No. of Dependents: _____

Employer: _____ Phone:_____ Occupation:_____

Student? ☐ F/T ☐ P/T Name of School: _____

Spouse: _____ SSN:_____ Occupation:_____

Employer: _____ Phone:_____

Emergency Contact Person: _____ Relationship:_____

Address: _____ Phone:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship:_____

Residence Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ SSN:_____

Employer: _____ # of Years Employed:_____

Employer's Address: _____ City:_____ State:_____ Zip:_____

Union Local #:_____ Work Phone:_____ Dental Insurance: _____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW:

PRIMARY INSURANCE (Use your Identification Card)

Insured Name: _____ SSN:_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employer:_____ Phone:_____ Union Local:_____

Insurance Company: _____ Group #:_____

Claims Address: _____ City:_____ State:_____ Zip:_____

SECONDARY INSURANCE (Use your Identification Card)

Insured Name: _____ SSN:_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Employer:_____ Phone:_____ Union Local:_____

Insurance Company: _____ Group #:_____

Claims Address: _____ City:_____ State:_____ Zip:_____