Patient Form

GARDEN GROVE
DENTAL & ORTHODONTICS

ID _____ Chart ID _____

Full Name (Required) _____

Patient is ☐ Policy Holder ☐ Responsible Party

Preferred Name _____

Responsible Party (if someone other than patient)

Name _____

Address _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ DOB _____ SSN _____

Drivers License _____

☐ Responsible Party is also a Policy Holder for Patient
☐ Primary Insurance Policy Holder
☐ Secondary Insurance Policy Holder

Patient Information

Address _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Sex ☐ Male ☐ Female ☐ Other

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email _____ ☐ I would like to receive correspondence via e-mail.

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Emergency Contact _____ Emergency Phone _____

Medicaid ID _____ Preferred Dentist _____

Employer ID _____ Preferred Pharmacy _____

Carrier ID _____ Preferred Hyg. _____

Primary Insurance Information

Name of Insured _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured SSN _____

Insured DOB _____ Employer _____

Insurance Company _____

Address _____

Rem Benefits _____ Rem Deduct _____

Secondary Insurance Information

Name of Insured _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured SSN _____

Insured DOB _____ Employer _____

Insurance Company _____

Address _____

Rem Benefits _____ Rem Deduct _____