KACY FAMILY DENTISTRY, PC
PATIENT INFORMATION FORM
PLEASE PRINT AND COMPLETE ENTIRE FORM

2020

CHILD'S INFORMATION

Patient Name: (Last, First, Middle)	Date of Birth Age Male ◯ Female ◯
Address	City State Zip
Phone # Cell ☐ Landline ☐	School Name Grade
E-mail Address- you will **ONLY** get Appt. Reminders	Social Security # - Our system requires a SS# on file
Primary Dental Insurance Compay:	Insurance ID # Group #
Secondary Dental Insurance Company:	Insurance ID # Group #
Emergency Contact: Name: Phone:	Who is Financially Responsible for Patient's Co-pays/Deductibles balance? (NOT INSURANCE)

PARENT'S INFORMATION

Father's Name (Last, First, Middle)	Father's Social Security #
Father's Employer	Father's Employer's Phone # ( )
Father's Birthdate:	Father's Dental Insurance Primary or Secondary?
Mother's Name (Last, First, Middle)	Mother's Social Security #
Mother's Employer	Mother's Employer's Phone # ( )
Mother's Birthdate:	Mother's Dental Insurance Primary or Secondary?

TODAY'S DATE: _____

Providers Initials	Date
Maximum 7 Initials	