Thomas LaMartina DDS
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PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

I grant my permission to you or your staff to call me at: ☐ HOME ☐ WORK ☐ Cell

How would you prefer to confirm appt.'s: ☐ Phone ☐ Text ☐ Email _____

Address: _____
Street Apartment # City State Zip Code

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____ ☐ Male ☐ Female, ☐ Married ☐ Single ☐ Child ☐ Other :_____
Last, First MI

SS #: _____ Birth Date: _____ Phone (Home): _____ (Cell):_____ _____ (Work): _____

Address: _____
Street Apartment # City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____ Occupation: _____

Address: _____
Street Apartment # City State Zip Code

INSURANCE INFORMATION

PRIMARY

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No Insured's Birth Date: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____ ID #: _____ Group #: _____

SECONDARY

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No Insured's Birth Date: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____ ID #: _____ Group #: _____

REFERRAL INFORMATION

How did you hear about us? ☐ Phone Book ☐ Internet/Website ☐ Hwy Billboard ☐ Insurance Plan ☐ Radio ☐ Newspaper ☐ Social Media

Another Patient _____ Dr. Office _____

Church _____ Other _____

Signature of patient, parent or guardian _____ Date: _____