J Martin Anderson DDS
221 South 2nd Suite 103
Kent, WA 98032

(253) 852-5155

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married/Domestic Partnership ☐ Widowed ☐ Divorced ☐ Single ☐ Minor

Home Phone _____ Cell Phone #1 _____ e-mail: _____

Employer _____Work Phone _____

Person to contact in case of emergency _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Referred to us by: _____

Former Dentist _____ Phone Number_____ Date of last visit_____

RESPONSIBLE PARTY (if other than patient)

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

INSURANCE INFORMATION

Name of Subscriber _____ Relation to Patient _____

Birthdate _____Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

If you have coverage with more than one insurance plan, please provide the information for the second plan below:

Name of Subscriber _____ Relation to Patient _____

Birthdate _____Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient