Welcome to Covington Family Dentistry

We look forward to taking excellent care of you.

Patient Information

Legal Name _____

Preferred Name _____

Gender: Male Female **Birth Date** _____ **Social Security #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Cell # _____ **Work #** _____ **Home #** _____

E-mail _____

Emergency contact _____ **Relation** _____ **Ph #** _____

How did you hear about our office? _____

Account Information

Is the patient financially responsible for himself or herself? Yes No

If someone other the patient will pay for the patient's treatment:

Name of responsible party _____

Relation to patient _____

Responsible party's signature _____

Cell # _____ **Work #** _____ **Home #** _____

E-mail _____

Address ☐**same as patient or:** _____

Insurance

Primary Dental Insurance Company _____

Employer _____ **Group #** _____

Subscriber _____

I.D. or S.S. # _____ **Birth Date** _____

Secondary Dental Insurance Company _____

Employer _____ **Group #** _____

Subscriber _____

I.D. or S.S. # _____ **Birth Date** _____

_____

Signature of Patient or Guardian **Date**