

# Shumway Dental Care

3150 S. Gilbert Rd. #1

Chandler AZ 85286

Phone: (480) 820-3400 Fax: (480) 820-5677

## PATIENT INFORMATION

### GENERAL INFORMATION

Mr. Ms. Mrs. Miss Dr.:

First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

If above is a minor, name of parent / guardian:

\_\_\_\_\_

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: H \_\_\_\_\_ W1 \_\_\_\_\_ W2 \_\_\_\_\_

E-mail: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: M F

Full time Student  
Where? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: S M D W Name of spouse/partner: \_\_\_\_\_

### DENTAL PLAN INFORMATION

Primary person insured: None Self Spouse Parent Other

Policy Holder's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID/SSN: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: H \_\_\_\_\_ W1 \_\_\_\_\_ W2 \_\_\_\_\_

**I authorize the release of information required for processing.**

Signature \_\_\_\_\_ Date \_\_\_\_\_