GREENSPOINT DENTAL

12523 Greenspoint Drive
Houston TX 77060

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party *☐I would like to receive correspondences via e-mail.

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address:

_____

City, State, Zip: _____ E-mail:*_____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

☐Responsible Party is also a Policy Holder for Patient ☐Primary Insurance Policy Holder ☐Secondary Insurance Policy Holder

Patient Information

Address: _____

City, State, Zip: _____ E-mail:*_____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed

Birth Date:_____ Age: _____ Soc.Sec: _____ Drivers Lic: _____

Employment Status: ☐Full Time ☐Part Time ☐Retired Student Status: ☐ Full Time ☐ Part Time

Referred by: _____

Previous Dentist: _____

Emergency Contact: _____ Emergency Contact #: _____

Primary Insurance Information

Name of Policy Holder: _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Soc. Sec: _____ Policy Holder Birth Date: _____

Employer: _____ Insurance Company: _____

Employer ID: _____ Insurance Address: _____

Insurance City,State,Zip: _____

Insurance Phone No.: _____

Secondary Insurance Information

Name of Policy Holder: _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Soc. Sec: _____ Policy Holder Birth Date: _____

Employer: _____ Insurance Company: _____

Employer ID: _____ Insurance Address: _____

Insurance City,State,Zip: _____

Insurance Phone No.: _____