LOVE TO SMILE OnSite

First Name:_____ **Last Name:**_____ **MI:**_____

Preferred Name:_____ **Birthdate:** _____

Address:_____ **City/State/Zip:**_____ **Home**

Ph: _____ **Cell Ph:** _____**Work Ph:** _____

E-mail:_____

Social Security Number: _____

Sex: ○Female ○Male **Marital Status:** ○Single ○Married ○Divorced ○Separated ○Widowed

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Preferred Pharmacy: _____

Emergency Contact

Name: _____ **Relationship:**_____ **Ph:**_____

Primary Insurance Information	**Secondary Insurance Information**
Policy Holder:_____	**Policy Holder:**_____
Patient's Relationship to Policy Holder:	**Patient's Relationship to Policy Holder:**
○ Self ○ Spouse ○ Child ○ Other	○ Self ○ Spouse ○ Child ○ Other
Insurance Company:_____	**Insurance Company:**_____
Member/Subscriber ID:_____	**Member/Subscriber ID:**_____
Subscriber Social Security #:_____	**Subscriber Social Security #:**_____
Group #:_____	**Group #:**_____
Phone Number:_____	**Phone Number:**_____
Address:_____	**Address:**_____
_____	_____