TROPICAL SMILES
Kendall R. Schumacher, DMD — Family Dentistry

PATIENT

LastName:_______________________ First Name____________________M.I:____

Marital Status: Single Married Divorced Widowed Male Female

Date of Birth: _______________Full- Time Student: Yes No If yes, where? __________

Address: ______________________________City:____________State:___Zip_________

Telephone Number _____________________Social Security Number_______________

Employer:_______________________________Work Phone:______________________

Employer's Address:____

Occupation:____

Spouse's Name____________________________________Date of Birth:_____________

Address:_________________________________City:___________State:____Zip:________

Telephone Number:______________________Social Security Number:_____________

Employer:_________________________________Work Phone:_____________________

Employer's Address:____

Occupation:____

PARENT INFORMATION (If patient is a minor)

If you are not the patient or parent, please indicate your relationship:_____________

Father's Name:____Date of Birth:_________

Address:_________________________________City:___________State:____Zip:________

Telephone Number:______________________Social Security Number:_____________

Employer:_________________________________Work Phone:_____________________

Employer's Address:____

Mother's Name:____Date of Birth:_________

Address:_________________________________City:___________State:____Zip:________

Telephone Number:______________________Social Security Number:_____________

Employer:_________________________________Work Phone:_____________________

Employer's Address:____

NEAREST RELATIVE (not living with you)

Last Name:______________________First Name_______________________M.I.______

Address:____________________________City:_________________State:____Zip______

Telephone Number:_________________________Social Security Number_____________

Whom may we thank for referring you to our office?

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INSURANCE INFORMATION

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

	Primary Dental Insurance	Secondary Dental Insurance
Name of Insurance Company		
Name of Employee		
Employee's SSN		
Employee's Birth Date		
Name of Employer		
Employee's Group #		
Address of Insurance Co.		
Phone # of Insurance Co.		