Maxine P. Vu, DDS
FAMILY AND COSMETIC DENTISTRY

Patient Information

Date: _____

Name _____ Birthdate_____ SS#: _____

Address _____ City_____ State _____Zip _____

Email_____ Cell phone:_____ Home phone: _____

Check Appropriate Box: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, name of School/College_____ City_____ State_____

Occupation _____ Employer _____

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account _____Relationship to patient _____

Address_____ Phone _____

Email _____Cell phone _____

Employer_____ Work Phone _____

Insurance Information

Name of Insured_____ Relationship to patient_____

Birthdate _____ SS# _____

Name of Employer _____ Union or Local # _____ Work ph._____

Address of Employer _____ City _____ State_____ Zip _____

Name of Insurance Company _____Group # _____ Policy # _____

Ins. Co. Address_____ City _____ State _____ Zip_____

Max. annual benefit_____ How much have you used? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If Yes, complete the following

Name of Insured_____ Relationship to patient_____

Birthdate _____ SS# _____

Name of Employer _____ Union or Local # _____ Work ph._____

Address of Employer _____ City _____ State_____ Zip _____

Name of Insurance Company _____Group # _____ Policy # _____

Ins. Co. Address_____ City _____State _____ Zip_____

Max. annual benefit_____ How much have you used? _____