Farley Family Dental
(801) 465-3256
805 South 500 West
Payson, Utah 84651

PATIENT INFORMATION SHEET

Date:_________________________ **Whom May we Thank for Referring you?:**____________________________

Patient's Name:______________________________**SSN:**____________________ **Birthdate:**__________ **Age:**_________

Address: ____

Phone #:______________________ Sex: M F Marital Status: M S W D No. of Dependents:___________

Employer:____ Phone:____

Emergency Contact Person:___________________________________ **Relationship:**____________________________

Address:____**Phone:**______________________________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:______________________________________ **Relationship:**_________________________

Residence Address:____

Hm. Phone #:____ SSN:____

Employer: ____ **# of Years Employed:**__________

Employer's Address:____ **C/S/Z:**____________________________

Union Local No.:__________________ **Wk. Phone #:**____________________ **Dental Insurance:**___________________

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW:

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name:_________________________________ **SSN:**_____________________________________

Patient's Relationship to Insured: Self:___________ **Spouse:**_________**Child:**________**Other:**____________

Employer:_______________________________________ **Phone #:**______________ **Union Local:**___________

Insurance Company:____ **Group # :**_____________________________

Claims address:____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name:____ **SSN:**_____________________

Patient's Relationship to Insured: Self:___________ **Spouse:**___________ **Child:**_______**Other:**__________

Employer:_______________________________________ **Phone #:**______________ **Union Local:**___________

Insurance Company:____ **Group # :**_____________________________

Claims address:____