Kent City Dental Center

Michael T. Watkins, D.D.S.

Patient Information (confidential): ***Today's Date_____***

Patient's Full Name (Last, First, Middle)_____ Birth Date _____

Gender: Male___ Female ____ Status: Married ___ Single ___ Other ___ e-mail address _____ _____

Social Security # _____ Driver's License # _____ State _____

Address _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Name of Employer _____ If Student Full time ____ Part time ___

Name of School _____ City in which school is located _____

Responsible Party Information:

Self ___ If Other, Full Name (Last, First, Middle) _____ Relationship to Patient _____

If "Other" please complete: Birth Date _____ Social Security _____

Driver's License # _____ State _____(need copy)

Address _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Employer _____ Phone _____

Address _____ Zip Code _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Address _____ Zip Code _____

Insurance Information:

Primary Insurance Company _____ Insurance Address _____

Group # _____ Subscriber ID (if available) _____

Name of Insured _____ Address _____

Insured's Birth Date _____ Social Security # _____ Phone Number _____

Name of Employer _____

Do you have any additional Insurance? NO ___ YES ___ If yes, please complete the following:

Secondary Insurance Company _____ Insurance Address _____

Group # _____ Subscriber ID (if available) _____

Name of Insured _____ Address _____

Insured's Birth Date _____ Social Security # _____ Phone Number _____

Name of Employer _____ **Signature _____**