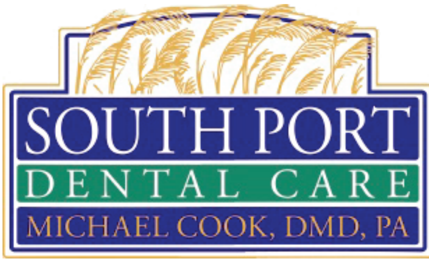



# Southport Dental Care

10690 South Federal Highway • Suite A
Port Saint Lucie, FL 34952
1 (772) 335-3300


# Patient Information

ID _______________ Chart ID _______________

First Name _______________ Last Name _______________ Middle Initial _______________ Preferred Name _______________

Patient is (circle one): Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name _______________ Last Name _______________ Middle Initial _______________

Address _______________ City, State, Zip _______________

Home Phone _______________ Work Phone, Ext _______________ Cell phone _______________

Birth Date _______________ Social Security Number _______________ Drivers License Number _______________

Responsible Party is (circle one): Also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

## Patient Information:

Address _______________ City, State, Zip _______________ Home Phone _______________

Work Phone, Ext _______________ Cell Phone _______________ Sex (circle one): M F Birth Date _______________ Age _______________

Marital Status: Married Single Divorced Separated Widowed Social Security Number _______________ Drivers License Number _______________

E-mail _______________ ○ Yes, I would like to receive correspondences via e-mail

Employment Status (circle one): Full Time Part Time Retired Student Status (circle one): Full Time Part Time

Medicaid ID _______________ Employer ID _______________ Carrier ED _______________ Pref. Dentist _______________

Pref Pharmacy _______________ Pref. Hyg _______________ Any Additional Comments: _______________

## Primary Insurance Information:

☐ I hereby authorize assignment of my insurance initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Name of Insured _______________ Relationship to Insured (circle one): Self Spouse Child Other Insured Social Security Number _______________

Insured Birth Date _______________ Employer _______________ Address _______________

City, State, Zip _______________ Insurance Company _______________ Address _______________

City, State, Zip _______________ Remaining Benefits _______________ Remaining Deductible _______________