Bush Family Dentistry
4112 6th Avenue | Kearney NE, 68845 | 308-236-9694

Name:_____ Birthday_____ SSN#_____

Preferred Name:_____ **E-Mail**_____

 Address_____ City_____ State_____ Zip_____

Home Phone (   )_____ **Work Phone** (   )_____Ext. _____ **Cell Phone** (   )_____

I would like to be notified of my appointments by   E-mail ☐   Text message ☐   Phone call ☐

Sex: ☐ **M**   ☐ **F**   **Status**: ☐ Married   ☐ Widowed ☐Single   ☐ Minor   ☐ Separated   ☐ Divorced

If a Student, Name of School/College _____City_____State_____   ☐ Full- time ☐   Part-time

Patient's Employer _____Occupation _____

Spouse or Emergency contact _____Employer_____Work Phone_____

RESPONSIBLE PARTY
Name of person Responsible for this account_____Relationship to patient _____

Address _____Home Phone _____Cell Phone_____
Social Security # _____ Birthdate_____
Employer_____ Work Phone_____
Is this person currently a patient in our office?   ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.   **Payment is required at the time of service.**
☐ Cash   ☐ Personal check   ☐ VISA   ☐ Mastercard   ☐ Discover   ☐ CareCredit (flexible payment plan WAC)

Whom may we thank for referring you? _____

Primary Dental Insurance:

Name of Insured _____ Relationship to patient _____

Address of policy holder _____ City _____ zip _____
            (if different from above)
Home Phone Number_____ Work Phone Number_____

Birthday_____   SSN/ID# _____

Insured's Employer _____Insurance Company _____

Insurance Company Address_____ City _____State _____Zip_____

Group Number _____ **Policy ID #**_____ Phone number_____

Is the patient covered by additional insurance: ☐ Yes ☐ No **If yes Complete the following:**

Additional Dental Insurance:
Name of Insured _____ Relationship to patient _____

Address of policy holder _____ City _____ zip _____

Home Phone Number_____ Work Phone Number_____

Birthday_____   SSN/ID# _____

Insured's Employer _____Insurance Company _____

Insurance Company Address_____ City _____State _____Zip_____

Group Number _____ **Policy ID #**_____ Phone number_____