

# WRIGHT DENTAL GROUP

1823 37<sup>th</sup> St. Everett, WA 98201  
(425) 258-3622

## Patient Information

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
How would you prefer to get appointment confirmations? Call: \_\_\_\_\_ Text: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  
Parent or Spouse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party

Relationship to Patient:  Self  Spouse  Parent  Other  
Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ SSN#: \_\_\_\_\_ Employer: \_\_\_\_\_

## Insurance Information

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Grp#: \_\_\_\_\_ ID#: \_\_\_\_\_  
Insurance Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

## Secondary Insurance Information

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Grp#: \_\_\_\_\_ ID#: \_\_\_\_\_  
Insurance Co Address: \_\_\_\_\_ Ins Co. Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_