East Limestone Family Dental
DR. SCOTT FITTS, DMD

Patient and Insurance Information

Name:_____ Prefered name:_____ DOB:_____

SS#_____ *Please circle*: Minor Single Married Divorced Widowed Separated

Address:_____ City:_____ State:_____

Zip:_____

Please circle the number you prefer to be reached at

Phone #: _____ Work # :_____ Cell #:_____

Email address:_____

Spouse or parent's name: _____ Phone #: _____

How did you hear about our office?_____

(friend/family, flier, drove by, other)

Responsible party if different than above

Name:_____ DOB: _____ SS#: _____

Address:_____ City:_____ State:_____

Zip:_____

Employer: _____ Work #:_____

Insurance Information (if you have your card you do not need to fill this section out)

Name of Insured:_____ DOB:_____ Relationship to patient:_____

SS#: _____ Employer:_____ Work Phone:_____

Insurance:_____ Group #:_____ID #:_____ Phone #:_____

----- Do you have any additional insurance? If so please complete the following -----

Name of Insured:_____ DOB:_____ Relationship to patient:_____

SS#: _____ Employer:_____ Work Phone:_____

Insurance:_____ Group #:_____ID #:_____ Phone #:_____