Wm. Todd Hamer, D.M.D. **Date: ____/____/_____**

Name:____ **Preferred Name**:____________________________
First **Middle Initial** **Last**

Home Phone:( )_______________________ **Cell Phone**:( )__________________________

Address:____**City:**______________________ **State:**_______ **Zip**__________

Sex: □ M □ F **Age**_______ **Birthdate**: _____/_____/_____ □ **Single** □ **Married**

Patient Employed By: ______________________________ **Email Address**: ____________________________________

Business Address: ____ Business **Phone**:( )_______________

Who may we thank for referring you? ____

Other family members seen in our office: ____

In case of emergency who should be notified? ______________________________ **Phone:**( )___________________

Person Responsible for Account: ____

PRIMARY INSURANCE

Subscriber Name:____
Last **First** **Middle Initial**

Relation to Patient: ______________ **Birthdate:** _____/_____/_____ **ID#/SS#**______________________________

Address (if different than patient): ____

Insured Employed By: ___________________________________ **Business Phone:**( )_______________________

Insurance Company: ____________________________________ **Group #:** _______________________________

Member ID/Subscriber #: ______________________________

ADDITIONAL INSURANCE

Subscriber Name:____
Last **First** **Middle Initial**

Relation to Patient: ________________ **Birthdate:** _____/_____/_____ **ID#/SS#**______________________________

Address (if different than patient):____

Insured Employed By: _________________________________ **Business Phone:(**)________________________

Insurance Company: ____________________________________ **Group #:** _________________________________

Member ID/Subscriber #: _____________________________

To the best of my knowledge all information is true and correct:

Signature: ____**Date:** ________________________