Coastal Dental Associates
118 Alden Road
Fairhaven, MA 02719
(508)994-2255

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Date

Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address: City State Zip Code

Preferred appointment times:

Pharmacy Name and Address

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Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Email Address:

Phone: Home | Work | Ext | Mobile Best time to call:

Address:
City | State | Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:
City | State | Zip Code

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Primary Insurance Information

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

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Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)