Dr. Goodheart Form
(please complete & return to receptionist)

Goodheart Dental
6530 Raytown Rd #A
Raytown, MO 64133
816-353-0673

SECTION 1: GENERAL INFORMATION

Today's Date:	NAME: Last, First, Middle		SOCIAL SECURITY NUMBER
ADDRESS Street or PO Box		City	State Zip
PHONE NUMBERS: Home	Cell		Work
E-MAIL	BIRTHDATE	☐ Male ☐ Female	SINGLE ☐ MARRIED ☐ DIVORCED ☐
OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	

SECTION 2: PARENT OR GUARDIAN INFORMATION

NAME: Last, First, Middle			RELATIONSHIP TO PATIENT
PHONE NUMBERS: Home	Cell		Work
ADDRESS Street or PO Box		City	State Zip
EMAIL	OCCUPATION	EMPLOYER	HOW LONG EMPLOYED

SECTION 3: PRIMARY INSURANCE INFORAMTION

SUBSCRIBER'S NAME: Last, First, Middle		DATE OF BIRTH	SOCIAL SECURITY OR SUBSCRIBER NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER'S NAME	WORK PHONE	NAME OF INSURANCE COMPANY
GROUP OR PLAN NUMBER	FULL ADDRESS OF INURANCE COMPANY		

SECTION 4: SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

SUBSCRIBER'S NAME: Last, First, Middle		DATE OF BIRTH	SOCIAL SECURITY OR SUBSCRIBER NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER'S NAME	WORK PHONE	NAME OF INSURANCE COMPANY
GROUP OR PLAN NUMBER	FULL ADDRESS OF INURANCE COMPANY		

SECTION 5: PERSON RESPONSIBLE FOR ACCOUNT

NAME: Last, First, Middle	RELATIONSHIP TO PATIENT	MALE ☐ FEMALE ☐	SOCIAL SECURITY #	DATE OF BIRTH
EMAIL	ADDRESS Street or PO Box	City	State	Zip
PHONE NUMBERS: Home	Cell		Work	

SECTION 6: GETTING TO KNOW YOU

PERSON TO CONTACT IN CASE OF EMERGENCY:		RELATIONSHIP TO PATIENT:
PHONE NUMBERS: Home	Cell	Work