PATIENT INFORMATION

Patient Name: ____ Date: ____________________

Address: ____

City: _______________________________________State: ___________ Zip: ________________

Social Security #: ________________________ Date of Birth __________________ Sex: ________

Telephone # Home: (____) ____________ Work: (____) _____________ Cell: (____) _____________

Email: ___________________________

Emergency contact: ____________________ Phone: (____)__________Relationship: ____________

Who can we thank for referring you? _________________________________

Do you have dental insurance? (Circle) YES NO

Do you have secondary dental insurance (circle) YES NO

Primary insurance:

Subscriber's Name: ______________________Subscriber date of birth: ___________________

Subscriber SSN: ___________________

Employer: ___________________ Employer Phone: ___________________

Relationship to subscriber: (circle) SELF SPOUSE CHILD OTHER

Insurance Company: ___________________ Insurance group number: ___________________

Insurance phone number: ___________________

Secondary insurance

Subscriber's Name: ___________________ Subscriber date of birth: ___________________

Subscriber SSN: ___________________

Employer: ___________________ Employer Phone: ___________________

Relationship to subscriber: (circle) SELF SPOUSE CHILD OTHER

Insurance Company: ___________________ Insurance group number: ___________________

Insurance phone number: ___________________

PLEASE PRESENT COPY OF YOUR INSURANCE CARD TO OUR FRONT DESK STAFF FOR PHOTOCOPY