Patient Information (Confidential)

Name ______________________ *Birth date* ______ *Home Phone* ____________

Mobile Phone __ ____________ *E-Mail* ____________________ ________

Address ______________________ *City* ____________ *State* *zip* ________

Social security Number ______________________

Please Check ❑ *Minor* ❑ *Single* ❑ *Married* ❑ *Divorced* ❑ *Widowed*

Patient's or Parents Employer ______________ **Work Phone** ________

Business Address ______________ *City* __________ *State* *Zip* ________

Spouse or Parents Name ______________________________

Employer ______________________ *Work Phone Number* ________

Person to Contact In case Of Emergency __________ *Phone* ________

Who May We Thank for Referring You? ______________________

Primary Dental Insurance Information

Name of Insured ______________________ *Relationship to Pt.* ________

Birth date ________ *Social Security #* __________ *Subscriber #* ________

Name of Employer ______________________ *Work Phone* ________

Address of Employer ______________ *City* __________ *State* *Zip* ______

Insurance Company ______________ *Group #* __________ *Plan #* ______

Insurance Co. Address ______________ *City* __________ *State* *Zip* ______

How Much is Your Deductible? ________ *Maximum Annual Benefit?* ________

Secondary Dental Insurance

Name of Insured ______________________ *Relationship to Pt.* ________

Birth date ________ *Social Security #* __________ *Subscriber #* ________

Name of Employer ______________________ *Work Phone* ________

Address of Employer ______________ *City* __________ *State* *Zip* ______

Insurance Company ______________ *Group #* __________ *Plan #* ______

Insurance Co. Address ______________ *City* __________ *State* *Zip* ______

How Much is Your Deductible? ________ *Maximum Annual Benefit?* ________