Patient Information:

Name:_______________________________________SS#__________________
Address: ____
City _____________________________________ State_______ Zip__________
Phone #______________________________Cell #________________________
Sex: Male____ Female_____ Birthdate_____________
Married _____ Single_____Divorced_____Widowed_____Separated_____
Occupation____
Employer____
Employer Address____
Bus. Phone______________________________
Who can we thank for referring you ___________________________________
In case of emergency notify____
Phone #_________________
Email Address: ____

Primary Dental Insurance:

Person responsible for the account______________________________________
Relation to patient___________Birth date____________SS#_______________
Insurance Company____
Ins. Co. Phone # ________________ Id #_____________Group#____________
Address____
Employer____

***Please give your insurance card to the front desk person to copy.**

Primary Health Insurance:

Health Insurance Co____
Group #______________Id #________________ Phone #____________________
Subscribe Name_________________________SSN#______________________
Relationship to patient____
Employer____
DOB____________Occupation____
Phone #__________________

***Your payment responsibility is to this office. The insurance company will reimburse you. We will file a maximum of two submissions per insurance claim. It is the patient's responsibility for any fees incurred at the time of the appointment. Please speak to the financial person for arrangements.**