Today's Date ______________

Mr/Mrs/Ms/Miss ____________ Birthday ______________ SS# ______________________

Address __________________________ City ______________ State _____ Zip ________

Home Phone ______________ Business Phone ____________ Cell Phone ____________

Marital Status ________ Spouse's Name ______________ SS# ______________________

Spouse's Birthdate _____________ Spouse's Contact Phone Number _______________

Person Responsible for This Account ______________ Relation to Patient ____________

Parent's Name (If Patient is a Minor) ____

Parent's Address (If Different From Above) ______________________________________

Parent's Contact Phone Number ____

Patient or Parent's Employer ____

Employer Address ______________________ City ___________ State _____ Zip _______

Spouse's or Parent's Employer ____

Spouse's Employer Address _____________________________ City ________________

Spouse's Employer State ___________ Zip _____________

Referred to This Office By ____

General Dentist's Name ____

Signature of Patient ____

Parent's Signature ____

(If Patient is a Minor)

IF YOU HAVE ANY DENTAL INSURANCE AND WANT OUR OFFICE TO SUBMIT IT FOR YOU, YOU MUST BRING A COMPLETED INSURANCE FORM OR AND INSURANCE CARD TO OUR OFFICE AND FILL OUT THE BACK PAGE OF THIS FORM. OTHERWISE, WE WILL NOT BE ABLE TO FILE INSURANCE FOR YOU.

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INSURANCE INFORMATION:

PRIMARY DENTAL INSURANCE INFORMATION:

Employee/Member/Subscriber Name: ______________________________

(Individual who carries insurance coverage)

Subscriber Address: ______________________________

City: ______________ State: __________ Zip: ________

Subscriber's SS#: ______________ Birthdate: __________

Insurance ID#: ______________________________

Relation to Patient: ______________ Group #: __________

Employer: ______________________________

Employer Address: ______________________________

Name of Insurance Company: ______________________________

Address: ______________________________

City: __________ State: ____ Zip: ______ Phone Number: __________

SECONDARY DENTAL INSURANCE INFORMATION:

Employee/Member/Subscriber Name: ______________________________

(Individual who carries insurance coverage)

Subscriber Address: ______________________________

City: ______________ State: __________ Zip: ________

Subscriber's SS#: ______________ Birthdate: __________

Insurance ID#: ______________________________

Relation to Patient: ______________ Group #: __________

Employer: ______________________________

Employer Address: ______________________________

Name of Insurance Company: ______________________________

Address: ______________________________

City: __________ State: ____ Zip: ______ Phone Number: __________