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.

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: _____