Patient Information

Last Name: ____________________________________
First Name: ____________________________________
Marital Status: __________________
Date of Birth #: ________________________
Home Address: _________________________________
City: _______________________ State: ____________
Zip Code: _________________
Home Phone #: _________________________________
Work Phone #: _________________________________
Cell Phone #: ___________________________________
E-mail Address: _________________________________

I preferred to be contacted: Home Number Cell Number E-mail

Emergency Contact name & number: _____________________________________

Pharmacy Name, Number & Address: _____________________________________

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Responsible Party: ______________________________
Billing Address (if different from above):

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Primary Dental Insurance _______________________ Group #: _____________
Claims Address____
Provider Phone Number ____
Subscriber Name: _______________________ Relationship: _________________
Member ID #: _________________________ If different from above…
Social Security #: _______________________ Date of Birth: _________________
Employer : ____________________________

Secondary Dental Insurance _____________________ Group #: ______________
Claims Address____
Provider Phone Number ____
Subscriber Name: _______________________ Relationship: _________________
Member ID #: __________________________
Social Security #: _______________________ Date of Birth: _________________
Employer : ____________________________

I understand that I am financially responsible for all charges of services rendered to me, including the balance and coinsurance remaining after payment of possible insurance benefits.

Signature: ___________________________________ Date: ____________________