Patient Information:

First name_____ Middle initial _____

Last name _____

Date of birth _____ Sex: ___ M ___ F

If patient is a minor, please list parent/guardian name_____

Soc. Sec. # _____

Address: _____

_____

home phone _____ work phone _____

cell phone _____ email _____

How did you hear about our practice? _____

Employer/Insurance Information:

Employer name _____

Position/title _____

Do you have DENTAL insurance coverage? _____ Y _____ N

Policyholder name _____

Relationship to you (patient) _____

Policyholder date of birth _____

Policyholder social security # *(we do need this information in order to properly file your claims. If you wish not to provide this information, we will be happy to provide you with a generic claim form to file on your own.)*

_____

Dental insurance carrier name _____

Insurance claims address _____

_____

Insurance group # _____