DENTISTRY
& ESTHETICS

PATIENT INFORMATION

Name: ______________________________ Social Security #: ____________________________________

Address: ____

City: _____________________________________ State: ___________ Zip Code: ____________________

Birth Date: _______________________________ Sex: M F (Please circle)

Cell Phone Number: _________________________ Home Number: ______________________________

*Which number is your primary contact number? ____

Email Address: ____

Whom should we notify in case of emergency? ____

Emergency Contact Phone Number: ____

Whom may we thank for referring you? ____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: ________________________________ Relationship: _______________________

Birth Date: _______________________________ Social Security #: _______________________________

Policyholder Employer: ________________________ Occupation: ________________________________

Address (if different from patient): ____

City: _____________________________________ State: ___________ Zip Code: ____________________

Insurance Company: ____

Group#: ___________________________________ Subscriber ID#: ___________________________________

Are other dependents covered under this policy? Yes / No

If yes, please list: ____

Do you have secondary insurance coverage? Yes / No

If yes, please list: ____