

Thank you for choosing our dental team. In order to provide you with the best dental care possible, please take a moment to completely fill out the following forms. We are happy to answer your questions or provide assistance where needed.

PATIENT INSURANCE INFORMATION

Legal Name: Last: _____, First _____, M.I. _____

Preferred Name: _____ D.O.B.: ____/____/____ [] Minor

Marital Status: [] Single [] Married [] Partnered [] Divorced [] Widowed

PRIMARY DENTAL INSURANCE INFORMATION

[] NO DENTAL INSURANCE

Insurance Name: _____ Phone# _____ Employer: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____ Group# _____

Policy Holder: _____ D.O.B.: ____/____/____ ID/SSN: _____

Relationship to Patient: [] Self [] Spouse [] Child [] Dependent [] Partner [] Other

SECONDARY DENTAL INSURANCE INFORMATION

[] NO SECONDARY DENTAL INSURANCE

Insurance Name: _____ Phone# _____ Employer: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____ Group# _____

Policy Holder: _____ D.O.B.: ____/____/____ ID/SSN: _____

Relationship to Patient: [] Self [] Spouse [] Child [] Dependent [] Partner [] Other

I hereby certify that all of the information provided by me in this form and all accompanying or required documents, is correct, accurate and complete to the best of my knowledge.

X

Signature & Date