CONFIDENTIAL **PATIENT INFORMATION** **PLEASE PRINT**

CIRCLE ONE MRS., MISS, MS., MR.., DR.

PATIENT NAME:____BIRTH DATE:___________________

SOCIAL SECURITY # :__________________________SEX:____GENERAL DENTIST___________________

PERSON RESPONSIBLE FOR ACCOUNT:____________________________PHONE:____________________

PATIENT ADDRESS:____________________________________ CITY/ZIP:_______________________

PHONE:______________________CELL:_____________________TEXT OK / NO

EMAIL:_____________________________________

PATIENT (or Parent) EMPLOYER:____PHONE:____________
EMPLOYER ADDRESS:____CITY:_____________________

SPOUSE EMPLOYER:____PHONE:___________________
EMPLOYER ADDRESS:____CITY:___________________

DENTAL INSURANCE INFORMATION-PRESENT YOUR CARDS

PRIMARY INS. CO. NAME:____________________________INSURED NAME:________________________

ID #:________________________ACCOUNT #:_______________BIRTHDATE:__________

SECONDARY INS. CO. NAME:________________________INSURED NAME:_________________________

ID#:_________________________ACCOUNT #:_______________BIRTHDATE__________

MEDICAL INSURANCE INFORMATION-PRESENT YOUR CARDS

PRIMARY INS. CO. NAME:___________________________INSURED NAME:__________________________

ID #:___________________ACCOUNT# :_____________________BIRTHDATE____________

SECONDARY INS. CO. NAME:___________________________INSURED NAME:______________________

ID# :___________________ACCOUNT#:______________________BIRTHDATE:___________

ACCIDENT INFORMATION (IF APPLICABLE)

DATE OF ACCIDENT:______________WORKMANS COMP: YES / NO

WHERE& WHAT HAPPENED:____

WHERE DO WE FILE CLAIMS:____

WHO CAN WE CONFIRM WITH (AGENT NAME):______________________PHONE #:__________________
CLAIM NUMBER:___________________________