Account # _____

WELCOME

PATIENT 'S NAME_____
PATIENT'S ADDRESS_____
CITY_____ZIP CODE_____
HOME PHONE_____ CELL PHONE_____
BIRTHDATE_____SOCIAL SECURITY #_____
EMPLOYER_____
EMPLOYER'S ADDRESS_____
_____
WORK PHONE_____ OCCUPATION_____
HOW LONG THERE?_____ MAY WE CALL YOU THERE ?_____
EMAIL ADDRESS _____
SPOUSE INFORMATION
HIS/HER NAME_____
EMPLOYER_____
WORK PHONE_____SOCIAL SECURITY#_____
BIRTHDATE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

DENTAL INSURANCE
INSURANCE CO. NAME_____
ADDRESS_____
PHONE #_____ GROUP #_____
SOCIAL SECURITY #_____INSURED'S NAME_____
RELATIONSHIP_____ INSURED'S EMPLOYER_____

ARE YOU COVERED BY MORE THAN ONE DENTAL INSURANCE PLAN?
INSURANCE CO. NAME_____
ADDRESS_____
PHONE #_____ GROUP #_____
SOCIAL SECURITY #_____INSURED'S NAME_____

THIS OFFICE WILL GLADLY SUBMIT FOR THE INSURANCE BENEFITS, HOWEVER YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLE AND BALANCE THAT ARE NOT COVERED BY INSURANCE.