*Please bring your current insurance card(s) along with your driver's license to your appointment*

Please ***print*** the following answers:

Patient's Name: ______________________________________

Preferred Name: ___________________ Middle Initial: ____

Birth date: ________________________ Gender: M / F

Address (Street): _____________________________________

City: ____________________ State: _____ Zip: __________

Home Phone: ________________________________________

Cell Phone: _______________Work Phone: ______________

Email: ____________________________________________

Patient's Social Security #: ________-_________-________

Marital Status: ______________________________________

Responsible Party Name: ______________________________

Address: ___________________________________

Phone (s): __________________________________

Referring Dentist: ____________________________________

Phone: _____________________________________

Pharmacy Name: _____________________________________

Phone & City:________________/_________________

Emergency Contact: __________________________________

Phone: _____________________________________

**PRIMARY DENTAL INSURANCE**

Policy Holder Name: _________________________________

Policy Holder Birth date: ______________________________

Social Security #: ____________________________________

Employer Name: _________________Group #:____________

Insurance Company: __ _______________________________

Insurance Address: ___________________________________

Insurance Phone: ___ _________________________________

Subscriber ID #: _____________________________________

**SECONDARY DENTAL INSURANCE**
**(If applicable)**

Policy Holder Name: _________________________________

Policy Holder Birth date: ______________________________

Social Security #: ____________________________________

Employer Name: _________________Group #:____________

Insurance Company: __ _______________________________

Insurance Address: ___________________________________

Insurance Phone: _____________________________________

Subscriber ID #: _____________________________________

**Patient/Guardian Signature: __________________________________________________ Date: _______________________**