

PLEASE PRINT CLEARLY

Date _____

Patient Name _____ Date of Birth _____ Age _____

Patient's Social Security # _____

Street _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Full Time Student Y / N If yes, name of school _____

Patient's Employer _____

Spouse's Name _____ Work Phone (____) _____

Nearest relative or friend not living with you:

Name (relationship) _____ Phone (____) _____

Referred By _____ Location _____ Phone (____) _____

(If other than your dentist)

Dentist _____ Location _____ Phone (____) _____

Physician _____ Location _____ Phone (____) _____

GUARANTOR -- PERSON TO GUARANTEE PAYMENT

Name _____ *(If "self", skip to primary insurance below)*

Street _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Guarantor's Social Security # _____

Date of Birth _____ Employer _____

Only complete the insurance information that pertains to you. Please present your insurance card and/or form to the receptionist so that we may submit your charges to your insurance carrier for payment.

PRIMARY INSURANCE COMPANY

Dental Insurance _____ Policy / Group # _____

Street _____ City _____ State _____ Zip Code _____

Phone (____) _____

Medical Insurance _____ Policy / Group # _____

Street _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone (____) _____

Policy Holder Name _____ Date of Birth _____

Policy Holder Social Security # _____

SECONDARY INSURANCE COMPANY

Dental Insurance _____ Policy / Group # _____

Street _____ City _____ State _____ Zip Code _____

Phone (____) _____

Medical Insurance _____ Policy / Group # _____

Street _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone (____) _____

Policy Holder Name _____ Date of Birth _____

Policy Holder Social Security # _____