Patient Name: ID #:

PATIENT, INSURANCE, PHARMACY INFORMATION

About You

First Name: _____ Middle initial: _____ Last Name: _____

Street: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: ____ Male _____Female _____Unspecified

SS#: _____

Preferred Phone #: _____ Is this a mobile number? Yes_____ No _____

Email address: _____

I would like to receive correspondence via email: ___**Y** ___ **N** I would like to receive correspondence via text: ___**Y** ___ **N**

Emergency Contact: _____ Emergency Phone #:_____

Who may we ***thank*** for referring you? _____

Responsible Party

First Name: _____ Middle initial: _____ Last Name:_____

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ____ Male _____Female _____Unspecified

Preferred Phone #: _____ Is this a mobile number? Yes_____ No _____

Signature: _____ Date: _____

Primary Dental Insurance

Is subscriber the same as patient? ___ **Y** ____**N** If No, what is the relationship to the patient: _____

Primary Insurance Co. Name: _____Phone #:_____

Subscriber ID/Policy #:_____ Group ID: ____ _____

Insured's Employer Name_____ Effective Date: _____

Insured's Name: _____ DOB: _____ SS #:_____

Secondary Dental Insurance

Is subscriber the same as patient? ___ **Y** ____**N** If No, what is the relationship to the patient: _____

Primary Insurance Co. Name: _____Phone #:_____

Subscriber ID/Policy #:_____ Group ID: ____ _____

Insured's Employer Na_____ Effective Date: _____

Insured's Name: _____ DOB: _____ SS #:_____

Preferred Pharmacy

Name: _____ Phone #: _____

Address: _____

Referring Dentist (if applicable)

Name: _____ Phone #: _____