



Today's Date \_\_\_\_\_

Mr/Mrs/Ms/Miss \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_ Spouse's Contact Phone Number \_\_\_\_\_

Person Responsible for This Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Parent's Name (If Patient is a Minor) \_\_\_\_\_

Parent's Address (If Different From Above) \_\_\_\_\_

Parent's Contact Phone Number \_\_\_\_\_

Patient or Parent's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's or Parent's Employer \_\_\_\_\_

Spouse's Employer Address \_\_\_\_\_ City \_\_\_\_\_

Spouse's Employer State \_\_\_\_\_ Zip \_\_\_\_\_

Referred to This Office By \_\_\_\_\_

General Dentist's Name \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Parent's Signature \_\_\_\_\_

(If Patient is a Minor)

**IF YOU HAVE ANY DENTAL INSURANCE AND WANT OUR OFFICE TO SUBMIT IT FOR YOU, YOU MUST BRING A COMPLETED INSURANCE FORM OR AND INSURANCE CARD TO OUR OFFICE AND FILL OUT THE BACK PAGE OF THIS FORM. OTHERWISE, WE WILL NOT BE ABLE TO FILE INSURANCE FOR YOU.**



## INSURANCE INFORMATION:

### PRIMARY DENTAL INSURANCE INFORMATION:

Employee/Member/Subscriber Name: \_\_\_\_\_

(Individual who carries insurance coverage)

Subscriber Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### SECONDARY DENTAL INSURANCE INFORMATION:

Employee/Member/Subscriber Name: \_\_\_\_\_

(Individual who carries insurance coverage)

Subscriber Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_