Date ______________

Patient's Name ______________________________

Birth Date ______________________ Age ______________

Spouse's Name ______________________________

If a Child, Parents Name ______________________________

Residence: Street ______________________________

City ______________________ State ______________ ZIP ______________

E-Mail Address ______________________________

Telephone (Home) ______________ Mobile ______________ Work ______________

Business Name ______________________________

Business Address ______________________________

Referred by ______________________________

Person Financially Responsible For Account ______________________________

INSURANCE INFORMATION

Employee's Name ______________________________

Company Name ______________________________

Employee's SSN ______________________ Employee's Birth Date ______________

Insurance Co. Name ______________________ Group # ______________

Insurance Co. Mailing Address ______________________________

List Persons Covered Under This Plan: ______________ ______________

______________ ______________

Do you have any other plans providing coverage? YES ☐ NO ☐ If YES, please give information below:

Employee's Name ______________________ SSN ______________

Company's Name ______________________ Address ______________

Insurance Co. Address ______________________ Policy # ______________

Insurance Co. Mailing Address ______________________________

Dependents Covered? ______________ ______________

______________ ______________

I give authorization to release personal health care information to my dental insurance company for reimbursement

Signature ______________________ Date ______________