PATIENT INSURANCE INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name _____ Today's Date _____

Sex _____ Age _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

Home Phone _____ E-Mail _____

Emergency Contact _____

Responsible Party's Name _____

Relationship to Insured _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Dental Insurance _____ ID Number _____

Medical Insurance _____ ID Number _____

Referring Dentist _____ Physician _____

Orthodontist _____

Reason for visit _____

Family members who have been patients here _____