Patient Information

NAME_____

SOCIAL SECURITY #_____

ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP CODE

BIRTHDATE_____

TELEPHONE (CELL)_____ (WORK)_____

EMAIL_____

REFERRED BY:_____

PRIMARY INSURANCE

As a courtesy to our patients, our office will submit all necessary forms to the insurance provided. It is important that we obtain the most accurate insurance information to ensure we send all claims to the proper insurance company as well as having them processed in a timely manner. To avoid any misunderstandings, be aware that any amounts not covered by the insurance provider is the responsibility of the patient.

Insurance Company_____
Name of policyholder_____
Name of employer_____
Policy holder birthdate_____
Relationship to patient_____
SSN# of policyholder_____
ID#_____
Group #_____


MIDTOWN
DENTAL
WELLNESS