OFFICE USE ONLY

_____ INITIAL FOR PROFILE UPDATED

_____ INITIAL FOR INSURANCE CARD SCANNED

_____ INITIAL FOR INSURANCE UPDATED

PATIENT INFORMATION

Today's Date: ________________________

Patient's Name: ____

Date of Birth: ______________________ Social Security Number: ______________________________

Home Phone Number: _____________________________ Cell Phone Number: _____________________________

Do you want to receive text confirmations/communication from us? Yes _____ No _____

Email Address: ____

Do you want to receive Emails from us? Yes _____ No _____

Address: ____

City: _____________________________ State: ___________ Zip Code: ___________

Preferred Pharmacy: ____

Have you had any recent medical issues/procedures/surgeries? ____

Please give Front Desk a list of any medications you are currently taking.

If patient is under 18 – Please complete the following:

Responsible Parties Name: ____

Resp Parties Date of Birth: ________________ Resp Parties Social Security #: ____________________________

Phone Numbers if different than listed above: ____

Address if different than listed above: ____

Insurance Information (If Applicable)

PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________________

Name of Policy Holder: ____________________________

Relationship to Insured: ( ) Self ( ) Spouse ( ) Child

Policy Holder's Date of Birth: _______________________

Policy Holder's SS#: ______________________________

Policy Holder's Employer: __________________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ______________________________

Name of Policy Holder: ____________________________

Relationship to Insured: ( ) Self ( ) Spouse ( ) Child

Policy Holder's Date of Birth: _______________________

Policy Holder's SS#: ______________________________

Policy Holder's Employer: __________________________

Please give a copy of your card(s) to the front desk or send a copy of your insurance information, including Employer, Carrier, Policy Number, and Group Number, to swiles@danvilledentalassociates.com

NEW PATIENTS:

How were you referred to us? _________________________ When was your last cleaning? __________________

Who was your last treating dentist? ____

____

Patient/Responsible Party Signature