PATIENT INFORMATION:

First Name_____ Last Name:_____ Pref Name:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Home#:_____Cell#:_____

Date of Birth:_____SS#:_____Drivers Lic#_____

Sex: M/F Employer:_____Work#:_____

EMERGENCY CONTACT NAME:_____ Phone#:_____

Spouse/Partner Name:_____Contact#:_____

Spouse/Partner Employer:_____Work#:_____

Please let us know how your heard about our office:_____

INSURANCE INFORMATION:

Primary Insurance Company: _____Phone:_____

Primary Policy Holder:_____ID#/SS#:_____

Group#:_____ Birthdate of Policy Holder:_____

Secondary Insurance Company:_____Phone:_____

Primary Policy Holder:_____ID#/SS#:_____

Group#:_____Birth date of Policy Holder:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Downtown Dental Care. I understand that I am financially responsible for any unpaid balance. I also authorize Downtown Dental Care or insurance company to release any information required to process my claims.

Print Name: _____Date:_____

Signature:_____Date:_____