DENTAL HEALTH
ASSOCIATES

PATIENT INFORMATION

First Name _____ **Middle Name** _____ **Last Name** _____

Birth Date _____ **Social Security #** _____ **Gender** _____ **Marital** _____

Home Address _____ **City** _____ **State/Zip** _____

Home Telephone # _____ **Work Telephone #** _____**Cell Telephone #** _____

Employer _____ **Address/City/State/Zip** _____

Spouse's Name _____ **Birth Date** _____ **Social Security #** _____

Spouse's Home Telephone #:_____ **Spouse's Work Telephone #:** _____

Spouse's Cell Telephone #:_____**Responsible Party if Patient is a Minor:**_____

Whom may we thank for your referral?_____

Your E-mail address: _____

How would you prefer that we confirm your appointments?**( )Home phone ( )Work phone ( )Cell Phone( ) E-mail**

INSURANCE INFORMATION

Medical Insurance:
Policyholder's Name _____ Relationship to patient: ( ) Spouse ( ) Parent ( ) Other_____
Policyholder's Birth Date ___/___/_____ Policyholders SSN# _____ Insurance Company_____
Policy # _____ Group # _____ Insurance Company phone # _____

Dental Insurance:
Policyholder's Name _____ Relationship to patient: ( ) Spouse ( ) Parent ( ) Other_____
Policyholder's Birth Date ___/___/_____ Policyholders SSN# _____ Insurance Company_____
Policy # _____ Group # _____ Insurance Company phone # _____

Do you have additional Dental Insurance? ( ) Yes ( ) No If YES, please complete the following:
Policyholder's Name _____ Relationship to patient: ( ) Spouse ( ) Parent ( ) Other_____
Policyholder's Birth Date ___/___/_____ Policyholders SSN# _____ Insurance Company_____
Policy # _____ Group # _____ Insurance Company phone # _____

PLEASE PRESENT INSURANCE CARDS FOR PHOTOCOPY