

How did you hear about our clinic: Facebook Billboard(Yellowstone) Gray's baseball field Your dentist Other _____

Patient Information

PLEASE PRINT

Name: _____ Gender: M / F Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____ Current Dentist: _____

DOB: _____ Home Phone #: _____ Cell #: _____ Email: _____

Driver's License Provided

Person Responsible For The Account (if it's the same as above just mark self.)

Self Spouse Guardian

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Home Phone #: _____ Cell #: _____

Dental Insurance Information (Please fill this section out completely)

Patient's Name: _____ DOB: _____ SS#: _____

Insurance Policy Holder's Name: _____ DOB: _____ SS#: _____

Insurance Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Insurance Policy Holder's Phone Number: _____ Relationship to the Patient: _____

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Employer's Phone: _____

Insurance Name: _____ Group#: _____ ID#: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Card Provided