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702.451.8181

Welcome! We are pleased to have you at our office. So that we may properly handle your account and the billing of your insurance claims, please fill this form out completely. We look forward to working with you in maintaining your dental health.

Patient Information

Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____ ☐ Male ☐ Female ☐Married ☐Single

Phone: _____ Cell: _____ Work: _____ E-mail: _____

Person Responsible for Account: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

Phone: _____ Cell: _____ Work: _____ Employer: _____

Whom may we thank for referring you to our office? _____

Insurance

Patient or Responsible Party is responsible for all services rendered regardless of insurance coverage.

Primary Insurance

Name of Subscriber: _____ Social Security Number: _____

Date of Birth: _____ Identification Number: _____ Group Number: _____

Employer: _____

Dental Insurance Carrier: _____

Address: _____ Phone: _____

Secondary Insurance

Name of Subscriber: _____ Social Security Number: _____

Date of Birth: _____ Identification Number: _____ Group Number: _____

Employer: _____

Dental Insurance Carrier: _____

Address: _____ Phone: _____