HERITAGE DENTAL PATIENT INFORMATION

Patient Name _____ Sex: M or F Birth Date _____
last first mi

Address_____
street city state zip

Home Phone_____ Cell Phone _____ Work Phone _____

Which # is best to reach you at? _____ Marital Status_____

SS # _____ E-Mail _____

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

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

Responsible Party Information (if different from above)

Name _____ Relationship to Patient _____

Address _____
(if different from above) street city state zip

Home Phone _____ Cell Phone _____ Work Phone _____
(if different from above) (if different from above) (if different from above)

SS # _____ E-Mail _____

Employer _____ Occupation _____

Dental Insurance Information (Please provide insurance card to photocopy)

Insured's Name _____ Birth Date_____

Employer's Name _____ SS#/ID#_____

Primary Dental Insurance Company Name_____

Insurance Company Address _____
street city state zip

Relationship to Patient _____

Secondary Dental Insurance

Insured's Name _____ Birth Date _____

Employer's Name _____ SS#/ID#_____

Secondary Dental Insurance Company Name _____

Insurance Company Address _____
street city state zip

Relationship to Patient _____

This hereby authorizes insurance benefits otherwise payable to me, directly to the above named dental group.

Signature _____ Date _____