gentle DENTISTRY

Patient Insurance Information

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ MI:____

Address:_____

City, State, Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Birth Date:_____

Social Security #:_____ Driver's License #:_____

___ Responsible party is also a Policy Holder for this patient ___ Primary Policy Holder

___ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured:_____ Relationship to Insured:_____

Insured Soc. Security #:_____ Insured Birth Date:_____

Employer & Address:_____

_____

Insurance Company & Address:_____

_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured:_____

Insured Soc. Security #:_____ Insured Birth Date:_____

Employer & Address:_____

_____

Insurance Company & Address:_____

_____