Sedona DENTAL ARTS

Patient Information Confidential

(PLEASE PRINT) DATE_____

Legal Name_____Preferred Name_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work_____

Preferred method of contact: Home Phone_____ Cell_____Text_____ Email_____

DATE OF BIRTH_____ Marital Status: __Married __Single __Divorced __Separated __Widowed

E-mail_____**Whom may we thank for referring you**?_____

PARTY RESPONSIBLE FOR THE BILLING (if different than above)

NAME_____Relationship to Pt_____

Patient Employer (Parent Employer, if minor)_____Phone_____

Person to Contact in Case of Emergency_____Phone_____

Dental Insurance Information

Name of Policy Holder_____Relationship to Pt_____

Policy Holder Soc. Sec. #_____Insured Birthdate_____

Group Number_____Policy ID Number_____

Employer or Ins Group Name_____Phone #_____

Insurance Co Name_____Phone #_____

DO YOU HAVE ANY SECONDARY DENTAL INSURANCE? __Yes __No If yes, please ask for a second form.